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DATE: 1984

THE EFFECTS OF DIAGNOSTIC LABELS AND DEGREE
OF BEHAVIORAL ABNORMALITY ON ATTITUDES
TOWARD FORMER MENTAL PATIENTS

by

Bernard J. Balleweg

B.S., Colorado State University, 1980

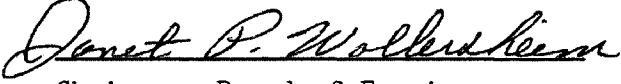
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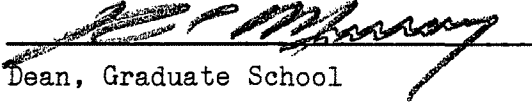
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ABSTRACT

Balleweg, Bernard J., M.A., 1983

The Effects of Diagnostic Labels and Degree of Behavioral Abnormality
on Attitudes Toward Former Mental Patients

Director: Janet P. Wollersheim, Ph.D. *JPW*

This investigation explored the long-term effects of diagnostic labeling on people's attitudes toward former mental patients in order to test the labeling theory proposition that the application of diagnostic labels to individuals exhibiting deviant behavior produces lasting social stigmatization. A sample of subjects from introductory psychology courses (120 males and 120 females) was randomly distributed among 10 experimental conditions, with 12 subjects of each gender serving within each condition. A 2 X 2 X 5 factorial design was employed in which the three independent variables were determined by: 1) sex of subject; 2) the presence or absence of a diagnostic label; and 3) the presentation of five patterns of symptoms corresponding to each label.

All subjects were told that they were participating in a study designed to evaluate inventories for assessing employers' attitudes toward job applicants. Subjects were asked to read a biographical sketch describing the job applicant's background, to view a 15-minute videotape of the applicant in a simulated interview with an employer, and to indicate whether or not they would hire the applicant. Subjects also evaluated the applicant on a variety of attitudinal and social rejection measures (the Personal Attribute Inventory (PAI), the Social Rejection Index (SRI), and the Evaluative, Potency, Activity, and Understandability factors of the Semantic Differential).

The 10 experimental conditions were determined by the biographical sketches which portrayed varying types of previous problem behaviors and labels. Five of the sketches contained descriptions of behaviors that characterized paranoid schizophrenia, major depression, alcoholism, a non-specific "mental illness", and a normal (control) individual. Four of the remaining five sketches contained identical behavioral descriptions but also had appropriate diagnostic labels ascribed to them; the fifth sketch served as a second control, identical to the first except for an added statement describing the applicant as highly efficient and reliable.

Data from each of the attitudinal/social rejection measures were analyzed with a 2 (sex of subject) X 2 (labeling) X 5 (behavioral description) ANOVA, and Neuman-Keuls tests were used to examine differences among group means. Chi-square tests were used to analyze frequency data generated from questions which asked if the applicant should be hired.

A significant sex effect was obtained on the SRI, the Understandability factor, and the hiring decision, with females consistently evaluating the applicant more negatively than males. The behavioral description manipulation produced significant group differences on the SRI, the Evaluative and Activity factors, and the hiring decision. In general, the abnormal behavioral descriptions consistently received higher social rejection ratings than control conditions but did not differ significantly from each other. No significant labeling effects were obtained on any measure. The implications of these results for labeling theory and for future research on attitudes toward the mentally ill are discussed.

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CHAPTER I

INTRODUCTION

The importance of studying societal attitudes toward the mentally ill has drawn increasing attention in recent years (Rabkin, 1972, 1974, 1980; Brockman, D'Arcy, & Edwards, 1979). This concern over public opinion closely parallels the increased emphasis on community-based treatments for the mentally ill which began in the late 1960's. In fact, Crocetti (1974) contends that the community mental health movement has made public attitudes toward mental patients one of the most important factors in the management of mental illness since both the establishment and the funding of community treatment facilities depends on a favorable climate of local public opinion. That contention is supported by Piasecki (1975) who estimates that for every community mental health agency that has been opened, another has been prevented from doing so by local opposition.

Favorable public attitudes are also extremely important for the successful rehabilitation of individual mental patients. A number of ex-patients have recounted the hardship they endured while trying to return to the community following their hospitalization (Kaplan, 1964). Rabkin (1974) notes, moreover, that being an ex-mental

patient is generally more of a liability than being an ex-criminal in the pursuit of housing, jobs, and interpersonal relationships. Clearly, such conditions hinder the readjustment of former patients and may exacerbate whatever social difficulties that arise from their disorders.

While mental health professionals are in agreement regarding the importance of public attitudes toward the mentally ill, they hold widely divergent views as to the current state of public opinion about mental illness. Two dominant orientations or viewpoints on that question have emerged: one largely optimistic, the other pessimistic (Rabkin, 1980). Members of the first group are largely positive about the public's ability to identify mental illness and to see it as an illness like any other. Proponents of this orientation tend to conceptualize mental disorders within the traditional psychiatric framework of a medical model. That is, they view mental illnesses as constellations of diseases with specific symptoms, courses, and outcomes. Crocetti and his associates are generally regarded as the leading advocates of this "optimistic" stance (Crocetti, Herzog, & Siassi, 1971; Crocetti, Spiro, Lemkau, & Siassi, 1972; Crocetti, Spiro, & Siassi, 1974). These researchers reject the notion that mental patients are stereotyped and stigmatized. They also cite data from their own community surveys to support their contention that people in general now require little social distance from

ex-mental patients and accept the medical model of mental illness.

The more pessimistic group of attitude investigators, is comprised chiefly of individuals with more of a sociological background (Rabkin, 1974). Members of this group reject the medical model of mental illness and regard diagnostic labeling as quite harmful (Sarbin & Mancuso, 1970; Scheff, 1966, 1975; Szasz, 1960, 1961). According to this viewpoint, what is called a "mental illness" is in reality an exaggerated pattern of behavior common to all people that is produced by stressful interactions between a person and his/her social environment. These researchers contend, moreover, that labeling a person as mentally ill stabilizes the deviant behavior because the label engenders a negative self-fulfilling prophecy and produces lasting stigmatization. The social reactionists view public attitudes toward those labeled mentally ill as highly negative and resistant to change.

In general, the majority of current data from research investigations regarding public attitudes toward mental illness tend to be more consistent with the pessimistic position taken by the social reactionists. Brockman, D'Arcy, and Edwards (1979) recently critiqued 22 attitudinal studies and noted a series of methodological problems common to all. However, these investigators concluded that overall the "negative findings are somewhat less suspect than the positive ones" (p. 679). They also reported data from

their own restudy of a sample originally interviewed by Cumming and Cumming (1957) and noted no significant changes in attitudes toward the mentally ill over the 23-year period studied.

Tringo (1970) reported a similar conclusion. He established a hierarchy of disability groups based on their relative degree of social acceptability and found that the mentally ill were the least preferred of the 21 different categories of disability. Both ex-convicts and mentally retarded individuals were seen as more desirable.

In addition, Olmsted and Durham (1979) reported the continued presence of negative attitudes within the college population. In this study, two sets of college students responded in 1962 and in 1971 to a series of semantic differential scales. The negative scores obtained were virtually identical for the two groups, suggesting the lack of noticeable improvement in attitudes during the time period investigated. The results were also highly similar to those reported by Nunnally (1961) which showed that the mentally ill were generally regarded as more worthless, dirty, dangerous, cold, and unpredictable than the "average" person.

Taken together, these studies and others like them (Colbert, Kalish, & Chang, 1973; Farina & Felner, 1973; Neff & Husaini, 1979) cumulatively suggest that attitudes toward the mentally ill are largely negative, have remained

relatively stable over the past two decades, and continue to be significant obstacles to the effective rehabilitation of individuals with mental problems. Such findings also cast doubt on the utility of encouraging the public to adopt a medical model of illness or to learn to identify and label mental illness (Rabkin, 1980). What these investigations do not address, however, is the origin of the stigma surrounding mental illness. Attempts to address that question have generated an oftentimes heated dispute in the past decade between adherents to the same two schools of thought noted above--the social reactionists and the proponents of the medical model. Adherents to the social reaction perspective, also known as labeling theorists, typically contend that negative attitudes toward the mentally ill are generated to a large extent by the mental illness labels given to individuals treated for mental problems. In contrast, those of the medical model persuasion argue that it is the deviant behavior exhibited by mental patients, not the label given to that behavior, that causes them to be stigmatized by others.

The current investigation was designed to address this dispute through procedures which assessed the long-term consequences of applying mental illness labels to abnormal behavior. However, in order to provide an empirical background for the present study, a more detailed explication of the labeling theory of mental illness will first be presented and critiqued. That exposition will be

followed with a review of the research that is consistent with the labeling perspective and of the literature that fails to support its primary tenets. Primary attention will be given to those investigations which explore the consequences of giving individuals mental illness labels.

Labeling Theory

Although the labeling perspective has largely been developed by sociologists, proponents of some version of the theory can be found in a number of different disciplines within the mental health field. The most notable advocates in psychiatry are Szasz (1961, 1970), Laing and Esterson (1964), Laing (1967), and Leifer (1969). Psychology is represented by Sarbin (1967a, 1976b, 1972) and Rosenhan (1973), anthropology by Goffman (1961), and sociology by Scheff (1966, 1970, 1974, 1975).

It is Scheff (1966, 1970), however, who provides the most explicit theoretical statement of how the labeling perspective explains mental illness. He bases his conceptualization upon the concept of "residual rule breaking." According to that formulation, all cultures have norms for behavior and a vocabulary of terms for categorizing violations of those norms (e.g., individuals who violate norms regarding property are called criminals). It so happens, however, that after all categories for labeling deviants are exhausted, there remains a "residue of the most diverse kinds of violations for which the culture provides no explicit label" (Scheff, 1966, p. 34). Scheff

calls these types of violations residual rule-breaking and states that it is the violation of residual rules that causes some individuals to be labeled mentally ill. He further contends that most psychiatric "symptoms" are in fact instances of residual rule-breaking or residual deviance. For example, inadequate levels of social interaction (often viewed as a symptom of schizophrenia) are violations of social norms regarding the proper level of social interaction.

It is important to note that Scheff's reformulation of symptoms as residual rule violations locates mental illness not in the symptomatology of disorderd individuals (as in the medical model) but in the categorizations observers make of various kinds of rule-violating behaviors. "Mental illness" becomes one category observers use to explain norm-violating behavior when they cannot explain it through other culturally recognizable categories. The entire "mental illness" metaphor, then, becomes little more than an explanatory device scarcely different than other outdated explanations for deviant behavior like demon possession.

Using his concept of residual deviance, Scheff (1975) goes on to formulate nine major hyptheses which form the core of the labeling theory of mental illness. They are as follows:

1. Residual rule breaking arises from fundamentally diverse sources (that is, organic, psychological, situations of stress, volitional acts of innovation or defiance).

2. Relative to the rate of treated mental illness, the rate of unrecorded residual rule breaking is extremely high.
3. Most residual rule breaking is "denied" and is of transitory significance.
4. Stereotyped imagery of mental disorder is learned in early childhood.
5. The stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction.
6. Labeled deviants may be rewarded for playing the stereotyped deviant role.
7. Labeled deviants are punished when they attempt to return to conventional roles.
8. In the crisis occurring when a residual rule breaker is publicly labeled, the deviant is highly suggestible and may accept the label.
9. Among residual rule breakers, labeling is the single most important cause of residual deviance (Scheff, 1975, p.10).

In sum, Scheff contends that nearly everyone at some time commits acts that correspond to the public stereotype of mental illness (i.e., residual rule violations), and that such acts are typically caused by a variety of factors and are transitory. Moreover, most residual rule breaking is denied by the public. In some cases, however, the residual rule breaker is publicly labeled as mentally ill. Whether or not this will happen depends on the patient's status in society, the patient's lack of power, the nature of the

residual rule violations, the social distance between the rule breaker and the control agents, and the overall community tolerance level. If labeling does occur, however, there is a high probability that the otherwise transitory deviant behavior will be stabilized, and the individual will be "launched on a career of chronic mental illness"(Scheff, 1975, p. 10). Scheff contends that the labeling process crystalizes the deviant behavior both by inducing the patient to adopt a negative self-fulfilling prophecy and by producing lasting stigmatization which effectively prohibits the patient from being reassimilated into community life. It follows that it is the processes that give rise to the labeling, rather than the denial, of residual rule breaking that are crucial to the production of chronic mental illness or "careers of residual deviance."

In summary, then, Scheff views mental illness primarily as an ascribed status which is entered into by factors primarily external to the individual, by societal reaction. Such a stance is strongly supported by Szasz (1960) who critiqued psychiatric diagnostic practice noting that psychiatric categories are not classifications of diseases that exist "out there" but are instead labels applied to disorganized social behavior. In his view, psychiatric diagnosis is little more than a process of labeling social behavior in terms of the ethical and social norms of society. In a similar manner, Mechanic (1978) states that "the application of disease labels to aspects of social

functioning is a social process of imposing standards of normality that characterize known populations, and the imposition of such standards may be used to assist persons in distress or to harm them" (p.382).

Scheff's (1966) initial formulation of labeling theory stimulated a major controversy in the mental health field throughout the past decade between advocates of the labeling perspective and proponents of the traditional psychiatric formulation of mental illness. This debate has included a rebuttal to Scheff's original position (Gove, 1970), replies to that rebuttal (Dunham, 1971; Mechanic, 1971; Akers, 1972; and Scheff, 1974a, 1976), and rebuttals to those replies (Gove, 1971, 1975a, 1976; Nettler, 1974 ; Chauncey, 1975). However, in a recent review of the controversy, Horwitz (1979) concluded that despite the above efforts, the central issues of the debate have not altered since Scheff's initial statement and Gove's first rebuttal. Indeed, different summaries of the same empirical literature conclude that labeling theory has been largely supported (Scheff, 1974a; Canover, 1976) or contend that it has been refuted (Gove, 1970, 1975b).

A detailed exposition of the critiques of labeling theory is beyond the scope of the current paper, and the interested reader is referred to the above citations for additional information. It should be noted, however, that the controversy centers about two crucial issues: the first concerns entry into the mental illness role, or the origin

of the "mental illness" label; the second concerns the effect of the mental illness labeling on individuals so labeled, or the consequences of labeling. Regarding the former question, labeling theorists contend that individuals are labeled mentally ill largely because they engage in residual rule violations, and due to their marginal status in society, are unable to contest the labels ascribed to them by those with greater social resources (e.g., psychiatric personnel). Adherents to the medical model, on the other hand, contend that behavior is labeled as a mental illness because it is symptomatic of underlying individual pathology, not because of the reaction of other, more powerful people. The vast majority of the empirical evidence on this issue seems to support the medical perspective. Included among the investigations that support the psychiatric perspective are: studies indicating that individuals placed in psychiatric hospitals typically exhibit severely impaired functioning for long periods of time prior to hospitalization (e.g., Goffman, 1971; Smith, Pumphrey, & Hall, 1963); studies indicating that a high percentage of hospitalized mental patients occupy the most powerful positions in their families (e.g., Horn, 1968; Linn, 1961); studies indicating that the vast majority of patients seeking psychiatric care do so voluntarily (due to personal distress) rather than through coercion from influential others (e.g., Kadushim, 1969; Saenger & Cummings, 1965); and, finally, studies supporting the role of biological /genetic factors in the etiology of several

major mental disorders (e.g., Heston, 1970; Slater, 1968; Reich, Clayton, & Winokur, 1969).

Collectively, these and similar investigations provide a prodigious amount of evidence against the labeling perspective of the origin of "mental illness" (Gove, 1975). However, these studies do not address the consequences of labeling--the degree to which mental illness labels effect the subsequent adjustment of an individual receiving mental health services. To date, the empirical evidence addressing that question is far more equivocal. Labeling theorists put forth data attesting to the deleterious effects of psychiatric labels, while those of the medical model persuasion marshal equally convincing research indicating that mental illness labels and psychiatric hospitalization result in little or no stigmatization and do not hinder subsequent adjustment. Since the current investigation focuses specifically on this aspect of the labeling controversy, a review of the literature pertaining to the effects of mental illness labels will now be presented in some detail, beginning with those studies which support labeling theory and ending with those that do not.

Empirical Evidence for Labeling Theory

Studies supporting the labeling perspective can be broadly divided into three sets according to the subject populations employed. The first group includes investigations which have explored the use of mental illness

labels among groups of mental health professionals (e.g., Carroll & Reppucci, 1978 ; Critchley, 1979; Langer & Abelson, 1974; Rosenhan, 1973; Temerlin, 1968, 1970). Others have explored the effects of mental illness labeling upon the attitudes and behaviors of employers and employees in the community (e.g., Farina & Felner, 1973; Farina, Felner, & Boudreau, 1973). The final group is comprised of investigations which explored labeling theory in the laboratory using college students as subjects (e.g., Leimkuhler & Zeigler, 1978; Loman & Larkin, 1976).

Temerlin (1968) was one of the first to experimentally explore the labeling process employed by mental health professionals. In that investigation, three experimental groups (psychiatrists, clinical psychologists, and graduate students in clinical psychology) were asked to listen to an audiotape recording of an interview with an actor who had memorized a script designed to make him appear normal according to a variety of criteria. Before the tape was played, however, each experimental group was told by a confederate that some well-known individual within their respective professions had "found the recording interesting because the patient looked neurotic but was actually quite psychotic" (p. 350).

Four control groups were also used. In the first, a matched group of professionals listened to the tape with no prior suggestion; in the second, the suggestion was reversed to suggest a healthy personality. The third and

fourth controls included a group of mental health professionals who were told they were listening to a recording of a "new kind of personnel interview" and a group of law students who listened to the tape as part of a mock sanity trial. After listening to the tape, all subjects were asked to diagnose the interviewee on a data sheet which listed a number of psychoses, neuroses, and personality disorders, and a category labeled "normal or healthy personality."

Striking and statistically significant differences were found between the categories of diagnoses chosen most frequently by each experimental group and between each experimental and control group. For example, no control subject ever diagnosed psychosis, while "in the experimental groups, diagnoses of psychoses were made by 60 % of the psychiatrists, 28 % of the clinical psychologists, and 11 % of the graduate students" (p. 351).

Temerlin concluded that these results were consistent with labeling theory as they indicated that psychiatric diagnoses can be markedly influenced by the interpersonal context in which those judgements are made. He stated, moreover, that this biasing effect would not have distorted true medical diagnosis so dramatically because the substantive reality of physical illness would counteract the distorting effects of prestige suggestion. Psychiatric diagnoses, on the other hand, can be distorted because they are based on clinical inferences made from observable

behavior that is judged appropriate or inappropriate according to the values of the diagnostician. According to this reasoning, psychiatric categories are not classifications of observable diseases that exist "out there," but instead are labels applied to disorganized social behavior.

A similar line of thought was advanced by Rosenhan (1973). In this highly publicized investigation, eight "normal" adults gained secret admission to 12 mental hospitals by reporting that they were hearing voices. On intake, seven of the subjects were given a diagnosis of schizophrenia; one was labeled a manic-depressive. All pseudopatients dropped all pretense of abnormality immediately after being admitted and remained in the hospital for an average of 19 days (range = 7 to 52). Throughout their periods of incarceration, none of the pseudopatients were detected by staff members even though they were frequently identified by patients who questioned their motives for being there.

Rosenhan indicated that these results buttressed his claim that the determination of "sanity" arises from the judgements of observers rather than from salient characteristics residing within the patient. In short, Rosenhan concluded that the "sane cannot be distinguished from the insane in psychiatric hospitals" (p.256). While such an assertion is highly consistent with the labeling perspective, its validity has been strongly challenged by a

number of critics (e.g., Crown, 1975; Millon, 1975; Spitzer, 1975; Weiner, 1975). These critics contend that the lack of appropriate control groups and the failure to keep subjects blind to the hypotheses being tested seriously flaw the experiment and make Rosenhan's conclusion untenable.

Additional controlled research is needed before this polemic can be adequately resolved. However, there were findings described in Rosenhan's paper that go beyond the purported inability of the hospital personnel to detect the pseudopatients. Perhaps of even greater significance is the reported tendency of staff members to interpret a pseudopatient's history and his/her current behavior in light of the diagnostic label. For example, it was observed in some instances that staff members unintentionally distorted the historical facts of cases when writing patient summaries to make the reports consistent with popular theory regarding the etiology of schizophrenia. Put more simply, the patient's past behavior was distorted to make it consistent with his/her diagnostic label rather than used as evidence against that label. A similar biasing effect was found in staff perceptions of the pseudopatient's ward behaviors which were often overlooked or profoundly misinterpreted. Nursing reports, for example, contain references to the pseudopatient's note-taking behavior which indicate that it was seen as a symptom of the patient's underlying disorder.

These findings are significant because they illustrate that a diagnostic label, once applied, may be extremely difficult to remove and may well lead to enduring stigmatization. As Rosenhan words it, "once a person has been designated abnormal, all his behaviors and characteristics are colored by that label" (p.253).

Even Rosenhan's critics concur with him on that point (Millon, 1975; Weiner, 1975; Spitzer, 1975). Millon (1965, p. 461) is particularly articulate in expressing his agreement:

Rosenhan is right in registering protest over the all too common practice of clinicians who seem content merely to label a patient as filling a category. Labeling is dangerous. It entails a reification, an impression that something has been identified as possessing intrinsic properties both salient and durable. Also by virtue of deriving its official sanction from the approved classification system, the belief is strengthened that a label designates a significant and valid attribute. Further, what is reified suggests permanence, and thus a label endures long after the symptoms that gave rise to it vanished. Because psychiatric labels convey perjorative implications, they remain as stigmas, result in social scapegoating and burdensome self-images, and thereby set the stage for self-fulfilling prophecies.

Thus, Rosenhan's investigation has challenged mental health professionals to consider the potentially deleterious effects of providing patients with psychiatric diagnoses. At the very least, Rosenhan's results show that diagnostic labels can markedly distort the manner in which a patient's past and current behavior is interpreted and treated by

mental health personnel. What is less apparent, however, is the purported long-term effect of the labeling process on a patient's subsequent readjustment. Rosenhan's assumption that labels produce lasting stigmatization and negative self-fulfilling prophecies has yet to receive adequate empirical verification. His contention that the negative effects of labeling can be eschewed by substituting descriptions of disturbed behavior also lacks research support. The current investigation was designed to examine both of these questions.

Langer and Abelson (1974) provide additional data attesting to the effect of labels on the judgement of clinicians. In this study, a group of clinicians representing a behavioral therapeutic orientation from State University of New York at Stony Brook and a group of analytically oriented therapists from the School of Psychiatry at Yale University viewed a single videotaped interview between a man and one of the authors. Half of each group was told that the interviewee was a "job applicant", while the remaining half was told that he was a "patient." All clinicians were asked to complete a questionnaire evaluating the interviewee at the end of the interview. Results indicated that the behavior therapists described the interviewee as well adjusted regardless of the label supplied. Analytic therapists, however, showed a strong labeling effect by describing the interviewee as significantly more disturbed when he was labeled a "patient"

than when he was designated as a "job applicant." Common descriptors used by analytic therapists who saw the job applicant were: "candid and innovative"; "ordinary, straightforward"; and "upstanding, middle-class-citizen type." In contrast, descriptions employed by analysts viewing the "patient" included: "tight, defensive person"; "conflict over homosexuality"; and "dependent, passive aggressive."

These findings provide further evidence that labels can dramatically effect the manner in which clinicians interpret the behavior of patients. In this case, the "patient" label caused the analytic therapists to imbue the interviewee with pathology and to interpret his behavior as symptomatic of underlying pathological conditions. The findings further suggest that labeling bias varies as a function of a therapist's theoretical orientation, with behavior therapists showing little response to labeling and those of an analytic persuasion being much more effected. Langer and Abelson hypothesized that the difference between the two groups was due principally to their training. Specifically, analytic therapists are trained to subscribe to a more traditional model of mental illness, whereas behavior therapists are trained to eschew diagnostic categories and labels and focus on observable behaviors. Although it is at this point untested, such a conclusion appears consistent with Rosenhan's claim that the harmful effects of labeling can be obviated by substituting behavioral descriptions of

maladaptive functioning in place of diagnostic labels.

In another study designed to assess the influence of diagnostic labels on the judgements of professionals, Critchley (1979) had psychiatric nursing students rate films of standardized play interviews with three normal children. Each subject was given an information booklet prior to each interview in which the child to be viewed was given a diagnosis of schizophrenia, obsessive-compulsive psychoneurosis, or normal. The results showed that students evaluated children labeled schizophrenic or obsessive-compulsive as significantly more disturbed than children labeled normal. Such findings further document the distorting influence that diagnostic labels can have on the perceptions of mental health personnel.

In a similar investigation (Caetano, 1974), samples of psychiatrists and students in an abnormal psychology class rated videotaped psychiatric interviews of a mental patient and a student. Half of each group were told that both interviews were with mental patients; the other half were told that both interviews were with students. Results indicated that both groups of subjects rated both the student and the mental patient as significantly more disturbed when given the suggestion of mental illness. In addition, the psychiatric sample exhibited a significantly greater labeling effect than the student sample.

To summarize, investigations exploring the effects of mental illness labels upon the perceptions of mental health professionals have shown that labels can markedly alter the way in which they interpret the behavior of labeled individuals, even to the extent that behavior that would otherwise be seen as normal is viewed as symptomatic. Such findings are highly consistent with the labeling perspective.

A second set of research supporting the labeling position is comprised of investigations which have tested the reaction of employers and employees to individuals who have been labeled as mental patients. For example, Farina and Felner (1973), tested the reactions of employers to former mental patients. These authors had a confederate posing as a job applicant secretly record 32 interviews with a variety of prospective employers. In half the interviews, the confederate indicated that he had been traveling for the preceeding 9 months, while in the remainder he stated that he had been in a mental hospital for an equal time period. Subsequent ratings of the recordings revealed that employers responding to the "former patient" exhibited less friendly behavior, offered half as many jobs, and rated the probability of the applicant finding a job elsewhere as much lower than employers who were told the applicant had been traveling. While this study does not address the effects of diagnostic labels per se, it does suggest that individuals labeled as "ex-mental patients" may face stigmatization and

discrimination in the job market.

The reactions of workers to job applicants labeled as former mental patients were also explored in a series of three studies reported by Farina, Felner, and Boudreau (1973). In the first investigation, female department store workers evaluated a female confederate job applicant who acted either calm or tense under conditions in which she was described as a former mental patient or a normal individual. The confederate was evaluated more negatively when she was tense, but the mental illness label had no effect. However, in a second study using a highly similar format, male hospital employees rejected a male confederate both when he was tense and when he had a history of mental illness. In the third study, female hospital workers rated a female confederate job applicant posing as a former mental patient in a fashion nearly identical to that observed in the first study. Thus, it appears that the sex of subjects and/or the patient is an important variable in the acceptance granted ex-mental patients. Specifically, females seem to accept other females labeled as former mental patients while males reject other males under similar circumstances.

The final set of investigations to be cited in support of the labeling perspective is comprised of analogue studies which have used college students as subjects. In one of the earlier studies of this variety, Farina, Holland, and Ring (1966) had a confederate reveal to groups of college students either that he had been hospitalized for mental

illness or that he was reasonably well adjusted. Subjects were subsequently placed in front of a panel of buttons, and the confederate was placed in front of a similar panel in an adjoining room. Subjects were then given a specified order of button presses and were instructed to try to communicate the appropriate order to the confederate by delivering electric shock, through a bogus apparatus, after each of the confederate's incorrect button presses. Despite the fact that the confederate behaved identically in all conditions, his behavior was judged less adequate, he was given more painful shocks, and he was liked less when he reported a history of mental illness. Consistent with the social reactionists perspective, the mental illness label markedly altered the manner in which he was perceived and treated.

Loman and Larkin (1976) used student subjects in an experiment designed to assess the relative contributions of labels and deviant behavior in the generation of negative attitudes toward the mentally ill. They asked different groups of subjects to rate a videotape of a counseling session with a young woman who was alternately labeled as a normal college student or a student having psychiatric problems with paranoid tendencies. The two behavior conditions were created by showing two versions of the videotape in which the student acted in a "normal" fashion or made statements that were moderately paranoid. A social rejection index and a rating of social competence were used as dependent measures.

Results indicated that both the label and behavior manipulations had significant main effects on the social rejection measure while only the labeling condition significantly influenced social competence scores. Thus, it appears that both labels and deviant behavior can lead to social rejection, but labels in and of themselves can lead to rejection in the absence of deviant behavior.

The Loman and Larkin (1976) investigation and most other investigations cited above explored reactions of subjects to labeled individuals who had allegedly been released from a mental institution in the recent past or were currently mentally ill. In contrast, Stensrud and Stensrud (1980) explored attitudes toward people who had been labeled mentally ill but who had subsequently demonstrated a normal and highly successful lifestyle. These researchers asked two groups of subjects to read a biographical sketch of an individual who was described as highly successful in a variety of respects, both in the past and in the present. However, the sketch for one group was altered slightly to indicate that the individual had sought psychiatric treatment for depression in the past. Findings revealed that the ex-patient was perceived as less internally controlled and more controlled by chance. Such results are also consistent with the labeling perspective as they indicate that perjorative connotations engendered by mental illness labels can endure and negatively influence peoples' perceptions even after a period of superior

post-treatment functioning.

In summary, a substantial body of literature has been published in support of the labeling theory of mental illness. Collectively, studies with mental health professionals, employers and employees in the community, and with college students have shown that mental illness labels can negatively influence peoples' perceptions, even to the extent that what would otherwise be viewed as normal behavior is seen as symptomatic of a pathological condition. Moreover, mental illness labeling has been linked with discriminatory attitudes in the job market and has been shown to produce negative evaluations in spite of evidence indicating superior post-treatment functioning.

While these results do not prove Scheff's contention that labeling is chiefly (or even largely) responsible for careers of mental illness, they do lend support to that hypothesis by indicating that labels can produce stigmatization that can hinder a mental patient's subsequent readjustment. In the final analysis, however, the results of these investigations must be weighed against those which are inconsistent with the labeling perspective. A review of that literature follows.

Empirical Evidence Against Labeling Theory

Studies presenting data contrary to the labeling perspective can also be grouped in accordance with the subject population employed. Some investigators have tested

the effects of mental illness labeling by interviewing former patients and their families (e.g., Gove & Fain, 1973; Huffine & Clausen, 1979; Schwartz, Meyers, & Astrachman, 1974), while others have explored the reaction of employers (e.g., Brand & Claiborn, 1976; Loeb, Wolf, Rosen, & Rutmen, 1968) and college students (e.g., Kirk, 1974, 1976; Lehman, Joy, Kriesman, & Summers, 1976) to individuals labeled as mentally ill.

In one of the major studies of former patients, Gove and Fain (1973) interviewed 429 individuals one year after they had been treated in a state mental hospital to determine if their hospitalization had produced stigmatization that hindered subsequent occupational or interpersonal adjustment. Regarding employment, the authors found that more men and considerably more women were employed one year after hospitalization than were employed in the period prior to their hospitalization. Moreover, more patients reported that they had more financial problems prior to hospitalization than following hospitalization. In terms of social adjustment, the majority of patients reported marked improvement in their relationships with people in the community subsequent to their treatment. Finally, only 12.7 % of all ex-patients believed they had been harmed by their hospitalization, while 84.2% stated that they had been helped.

These findings are all highly inconsistent with the labeling perspective which contends that patients are likely to be so stigmatized by having been labeled mentally ill that they have great difficulty resuming previous interpersonal and occupational roles. Clearly, the results show that most patients demonstrated improved functioning after treatment and experienced little stigmatization. Such findings suggest that labeling has a much smaller impact than that suggested by the social reactionists.

Similar results were reported by Huffine and Clausen (1979) in a study which explored the effects of mental illness on occupational careers. In 1972, these authors interviewed 36 married men who first entered mental hospitals in the 1950's and obtained information regarding their occupational histories and the effects of their illnesses and hospitalization on their jobs. They found that 80 % of these men returned to their former jobs within 1 month of their release, and most of the men either perceived no change in their relationships with co-workers or found their colleagues sympathetic or conciliatory. Moreover, the factor that was found to be most predictive of successful post-hospitalization occupational adjustment was not the degree of stigma engendered by the hospitalization but the presence of a stable occupational history prior to treatment.

These data are consistent with Gove and Fain's (1973) findings and provide substantial evidence that being labeled mentally ill does not, in and of itself, significantly alter the course of a man's career. However, because the subject sample was comprised of first-admission patients who were married (both factors being associated with a favorable prognosis), caution should be used in generalizing these findings to other mental patients.

Schwartz, Myers, and Astracham (1974) explored the influence of psychiatric labeling on attitudes of relatives of former mental patients. The authors evaluated a group of 132 schizophrenics 2 years after they were discharged from an inpatient psychiatric setting to assess mental status and social adjustment. They also interviewed and administered a social distance scale to 124 relatives of the former patients and ran a series of regression analyses to determine which of a variety of factors were most highly related to high social distance scores. The authors found that 51 % of the relatives expressed social distance reactions to the mentally ill. However, analyses of the factors producing the social stigma led the authors to conclude that "psychiatric treatment is of lesser importance in determining rejection of the mentally ill than the ex-patient's level of impaired mental status" (p. 333). Thus, the findings of Schwartz et al. suggest that the degree to which former patients are stigmatized is principally determined by the amount of deviant behavior

they display after treatment. That conclusion is highly incompatible with labeling theory and has been corroborated by several other investigations (e.g., Angrist, Lefton, Dinitz, & Pasamanick, 1968; Gove, 1970, 1972).

In summary, studies of former mental patients have generally revealed that their hospitalization has not resulted in lasting stigmatization resulting in careers of "residual deviance." On the contrary, the data suggest that ex-patients tend to function socially and occupationally at levels that equal or exceed their pre-hospital adjustment and are not likely to be rejected unless they continue to exhibit pathological behavior.

Several investigations exploring the effects of labeling on the attitudes of employers have also yielded results that dispute the labeling perspective. In one of these studies, Loeb, Wolf, Rosen, and Rutman (1968) tested the effect of diagnostic labels and severity of illness or the judgements made of ex-mental patients. The authors asked a group of vocational rehabilitation counselors and a group of businessmen to rate biographical sketches of a job applicant using Likert scales designed to assess degree of employability, social acceptance, and psychiatric status. For the severity of illness manipulation, adjectives were incorporated into each sketch that corresponded to high, moderate, and low levels of abnormality. For example, the applicant was alternately described as facing difficult decisions in a "despondent", "solemn", or "sober" manner.

For the labeling manipulation, the applicant was described as a person recently discharged from a psychiatric hospital where he was treated for paranoid schizophrenia, a nervous breakdown, or various interpersonal problems. In a control condition, he was described simply as a person who had recently applied for a job in a large corporation.

The results indicated that the degree of behavioral abnormality strongly effected attitudes while the labeling condition yielded no effect. Specifically, both groups of subjects rated applicants described with low abnormality adjectives as more employable, more socially acceptable, and less psychiatrically disturbed, as compared with the moderate and high abnormality descriptions. No differences were observed between the two groups of raters. Thus, the data suggest that the factor most likely to lead to rejection is the disturbed behavior manifested by the ex-patient, not the label attached to that behavior.

In another pair of investigations, Brand and Claiborn (1976) compared employer attitudes toward individuals labeled as former convicts, mental patients, or tuberculosis patients. In the first study, questionnaire packets containing descriptions of one of the three types of individuals and social distance scales were sent to 200 employers. The results of the survey indicated that ex-tuberculosis patients were significantly less stigmatized than were the other two conditions. In the second study, graduate students serving as confederates participated in

actual job interviews in which they alternatively presented themselves as ex-convicts, ex-mental patients, or former tuberculosis patients. No significant differences in the number of jobs offered were found among the three conditions. In fact, two thirds of the applicants in all three groups received offers of employment. Collectively, then, the findings of these two studies suggest that while employers may hold less favorable attitudes toward former mental patients, relative to former medical patients, they may not overtly discriminate between the two groups in their hiring practices.

Several investigators have tested labeling theory under controlled laboratory conditions. Lehman, Joy, Kreisman, and Simmens (1976) conducted an experiment to determine whether a psychiatric label or symptomatic behavior would be more likely to generate prejudicial attitudes towards a person viewed on videotape. College student subjects watched three separate videotapes of individuals who acted in an anxious, depressed, or normal fashion while performing identical tasks. One of the taped sequences for each subject was described as a former mental patient. Although symptomatic behaviors were found to produce negative ratings on a social distance scale, the labeling condition had no effect. Similarly, actors showing symptomatic behaviors were rated as more dangerous, irresponsible, and unpredictable, while labeled actors were only rated less predictable. On the basis of these findings, the authors

concluded that in all likelihood "any rejection directed towards psychiatric patients comes from their aberrant behavior rather than from the label that has been applied to them" (p. 332).

Kirk's (1974) findings led him to the same conclusion. He asked 864 community college students to rate case vignettes. Each vignette contained a description of deviant behavior, a label for that behavior, and a designation of the type of person ascribing the label. Specifically, a 3x3x4 factorial design was used to evaluate three different case descriptions (a paranoid psychotic, a depressed and anxious neurotic, and a normal person). At the conclusion of each description, a particular person (a psychiatrist, the labeled individual's family, the labeled person himself, or some unspecific people) offered an interpretation (label) for the deviant behavior described. In one version, the individual was said to be "mentally ill," in another he was labeled as "wicked," and in a third he was designated as a normal person "under too much stress." Subjects' reactions to the vignettes were measured with a social rejection index.

Results showed that only the behavior variable produced significant effects. This finding corroborates the findings of Lehman et al. (1976) and Loeb et al. (1968) and those of several others (e.g., Bentz & Edgerton, 1971; Spiro, Siassi, & Crocetti, 1973) which have shown that labeling deviant behavior has no influence on attitudes independent

of the disturbed behavior itself. Cumulatively, these data lend no support to the labeling theory contention that the use of labels markedly alters the manner in which people interpret and respond to abnormal behavior.

It can be concluded, then, that there is a sizable amount of empirical evidence against the labeling theory of mental illness. Reports from former mental patients have indicated that most face little stigmatization that hinders their subsequent occupational or social functioning. Moreover, experimental investigations with both businessmen and college students have shown that deviant behavior, not the label given to that behavior, produces social rejection.

Clearly, these findings contrast sharply with those cited previously in support of the labeling theory of mental illness. Unfortunately, it is difficult to resolve the inconsistencies between these two bodies of research given the wide disparities in methodology used to test the labeling perspective. Nevertheless, several central methodological problems have been described that are germane to the design of the current study (Brockman, D'Arcy, & Edmonds, 1979; Lehman, Joy, Kreisman, & Simmons, 1976).

First, the style of patient presentation has varied markedly from investigation to investigation. For example, many of the the experimental studies which have shown no labeling effect have asked subjects to rate vignettes or case abstracts which contain brief descriptions of various

categories of mental illness (e.g., Bentz & Edgerton, 1974 ; Kirk, 1974, 1976). Loman and Larkin (1976) have criticized this practice as an invalid test of labeling theory as it requires subjects to respond to a hypothetical individual in the abstract rather than to a real individual interacting within a specific situational context. These researchers contend, moreover, that the vignettes have often contained informal labels such as "very quiet" or "afraid of people," which are perjorative trait character referents. To circumvent these problems, Loman and Larkin advocate the use of videotaped presentations of labeled individuals in place of written vignettes. Interestingly, many of the investigations which most strongly support labeling theory have used labeled individuals that were presented via video- or audiotape (e.g., Caetano, 1977; Critchley, 1979; Langer & Abelson, 1974; Loman & Larkin, 1976; Temerlin, 1968).

Secondly, wide differences in methodology have resulted in differential control over demand characteristics. Brockman et al. (1979) have noted that many of the studies used as evidence against labeling theory have obtained their data through interviews and, therefore, may have been confounded by the respondent's wish to please the interviewer. Similarly, Lehman et al. (1976) contend that many studies reporting no labeling effect have been conducted in settings that encourage sympathetic attitudes toward the mentally ill. In contrast, many of the studies supporting the labeling perspective have disguised the true

nature of the investigation from the subjects used, thereby minimizing the tendency of subjects to respond in a socially desirable fashion.

Third, wide fluctuations are apparent in the degree to which each of the studies reported were designed to address the short- or long-term effects of labeling. Most of the investigations cited in support of labeling theory have seemingly been most concerned with short-term effects and have addressed that dimension by having subjects rate vignettes, audiotapes, or videotapes in which individuals are portrayed as mental patients, or by having employers and employees respond to individuals described as recently discharged patients. In contrast, much of the survey-style literature refuting the labeling perspective has been devoted to assessing the long-term consequences of psychiatric labeling and hospitalization. To date, very little experimental research has been reported on either side of the controversy that is specifically designed to determine if former patients are likely to be stigmatized even after a period of successful posttreatment functioning.

Finally, a wide variety of dependent measures have been used to quantify social rejection (Brockman et al.; 1979). Many investigations have developed scales tailored for their individual projects and have reported limited information regarding the validity and reliability of their instruments. Thus, the results obtained in any given study may be principally a function of the measure of social rejection

employed.

Experimental Proposal

The current investigation was designed to experimentally explore the long-term effects of mental illness labeling while attending to each of the aforementioned methodological concerns. Specifically, the present study tested the labeling theory tenet that mental illness labels applied to abnormal behavior are capable of producing lasting social rejection, independent of the deviant behavior itself.

To test that assumption, 10 groups of college students were asked to view a simulated videotape of an individual applying for a job and were subsequently asked to rate that individual on several measures of social rejection. Prior to viewing the videotape, each subject was asked to read a biographical sketch of the applicant which contained one of five possible descriptions of symptoms associated with a previously treated mental condition (paranoid schizophrenia, alcoholism, depression, mental illness, or a normal control). Half of the vignettes for each of the five symptom clusters contained a diagnostic label corresponding to the symptoms described; the remainder remained unlabeled. Equal numbers of males and females were assigned to each of the 10 experimental conditions so that subsequent analyses for gender effects could be performed. The importance of testing for sex effects was suggested by previously cited research that reported significant gender

differences in attitudes toward former mental patients (e.g., Farina, Felner, & Boudreau, 1973).

To allow for an assessment of the purported long-term stigmatizing influence of labels, the biographical sketches for all subjects contained information suggesting a high level of posttreatment social and occupational adjustment. Moreover, the actor posing as the applicant in the videotape followed a script designed to make him appear normal in all respects.

On the basis of labeling theory and the results of previous research, it was hypothesized that: 1) subjects given labeled biographical sketches would obtain significantly different social rejection scores than subjects in unlabeled groups on all dependent measures; 2) the five types of mental conditions described in the biographical sketches would receive significantly different social rejection ratings across all dependent measures; and 3) males and females would obtain significantly different social rejection scores across all dependent measures.

CHAPTER II

METHOD

Subjects

Subjects for the current investigation were 120 male and 120 female students enrolled in introductory psychology courses at the University of Montana. All participants were given course credit for being in the study. Prospective subjects were told that they would be taking part in a study designed to evaluate different devices for measuring employers' attitudes toward job applicants. Twenty groups were formed by randomly assigning 12 males and 12 females to each of the 10 treatment conditions described above.

Experimental Design

The experiment employed a 2X2X5 factorial design (A X B X C). The gender variable (males versus females) was designated as the A effect, the labeling condition (labeled versus unlabeled) was designated as the B effect, and the five types of behavioral patterns representative of each of the five labels used (paranoid schizophrenia, depression, alcoholism, mental illness, and a normal control) comprised the C effect.

Dependent Measures

In a recent review of the methodology used in prior investigations designed to assess public attitudes toward

the mentally ill, Brockman, D'Arcy, and Edmonds (1979) emphasized the fact that public attitudes are "multifaceted, highly complex, and difficult to evaluate" (p. 673). These investigators further stressed the limitations of current assessment instruments and argued for the use of multiple assessment devices both to overcome limitations idiosyncratic to any one instrument and to tap more fully the various dimensions of attitudes. In order to address that concern, several dependent measures were employed in the present study.

Personal Attribute Inventory (PAI). Developed by Parish, Bryant, and Shirazi (1976a, see Appendix B), the PAI was designed to assess the evaluative-affective component of attitudes, a dimension often viewed as the central feature of attitudinal definitions (Shaw & Wright, 1967). The inventory consists of 50 positive and 50 negative adjectives which were selected from Gough's (1952) Adjective Check List. Only items which were consensually judged positive or negative by at least 95% of a sample of 127 college students were included in the final version of the scale. From the resulting list of 100 adjectives, subjects are instructed to select 30 which are most descriptive of a target group or person. The total PAI score is simply the number of negative words marked by each subject. Thus, scores range from 0 to 30, or from very positive to very negative respectively.

Data reported by Parish et al. (1976a, 1976b) suggest that the PAI is a highly stable and reasonably valid

attitudinal measure. Using the word "Negroes" as the target stimulus for three different subject samples, these investigators obtained test-retest reliabilities of .90, .94, and .95. An attempt was also made to establish criterion-related validity by comparing scores on the PAI with those on two scales designed to measure attitudes toward Negroes, the Westie Summated Differences Scale (1953) and the Ewens Adjective Checklist (1969). Significantly high correlations were obtained for both comparisons. Although additional research to further validate the PAI is clearly needed, it appears that the results already obtained are more extensive than those reported for most attitudinal scales (Bonjean, Hill, & McLemore, 1967).

In summary, the PAI was considered to be an appropriate instrument for the current study because it is a highly stable and reasonably valid attitudinal measure. Its inclusion was further warranted by the fact that it was specifically constructed to tap the central evaluative component of subjects' attitudes.

Social Rejection Index. The Social Rejection Index (SRI) was developed by Kirk (1974) as an instrument for measuring social rejection. In constructing this measure, Kirk borrowed five items from a previously constructed social distance scale (Phillips, 1963) and incorporated 10 original items designed to assess social rejection in common situations. He then administered all 15 items to a sample of 864 college students who were asked to use them to rate vignettes depicting individuals with various types of mental

illness. The responses were factor analyzed, and nine items which accounted for the most communality (each with a factor loading greater than .60) were chosen for inclusion in the final form of the SRI (see Appendix C).

The wording of each question on the SRI is varied so that an affirmative response sometimes indicates acceptance of the target (e.g., "If I were working for this man, I would probably think he was a good boss?") and sometimes denotes rejection (e.g., "I would discourage my children from marrying someone like this?"). Subjects are asked to respond to each question on a three-point scale (disagree, uncertain, agree), and each response is assigned a value of 3 (rejecting response), 2 (uncertain response), or 1 (accepting response). The values of the answers to the nine items are summed to obtain a subject's total SRI score. Thus, final scale scores may range from 9 (strong acceptance) to 27 (strong rejection).

Although little data has been reported concerning the reliability and validity of the SRI, its inclusion in the current investigation was deemed to be warranted in order to allow for direct comparison of the results with other labeling investigations which have used the measure (e.g., Kirk, 1974; Loman & Larkin, 1976). The importance of including a measure of social rejection is further indicated by social reaction theorists who contend that mental illness labels are harmful because they lead to social rejection and stigmatization. The SRI appears highly suitable as an instrument for testing that assumption as it provides an

index of social rejection in commonly encountered real-life situations, unlike many other attitude scales which provide more global evaluative ratings of individuals or concepts.

Semantic Differential. Developed by Osgood, Tannenbaum, and Suci (1957), the Semantic Differential (SD) is an instrument which requires subjects to rate a concept or person on pairs of bipolar adjectives called scales. Subjects are asked to rate each scale (e.g., weak-strong) on a seven-point continuum. Thus, a subject's rating of a target person or concept on the "weak-strong" scale may range from extremely weak, which receives a score of one, to extremely strong, which receives a rating of seven.

One important advantage of the SD is that it provides not only an overall index of attitudes but different facets of meaning as well. Osgood et al. (1957) factor analyzed responses to numerous scales that were used to rate a variety of concepts. In doing so, they extracted three major factors: (1) Evaluative, comprised of scales like good-bad and valuable-worthless; (2) Potency, comprised of scales like strong-weak and rugged-delicate; and (3) Activity, comprised of scales like active-passive and fast-slow. The Evaluative factor appears to denote the good-bad aspect of meaning and accounts for the vast majority of the extracted variance. Osgood et al. (1957) obtained high correlations between this factor and conventional attitude-measuring instruments. The Potency and Activity factors account for much less of the variance but are nevertheless judged to be important as they measure

different aspects of attitudes and may therefore account for the differential meanings of concepts to subjects.

The reliability checks performed by Osgood et al. (1957) further support the utility of the SD as a measure of attitudes. They reported the results from a study in which 40 items from the original sample of 1000 were randomly selected and readministered to a group of 100 subjects. The resultant reliability coefficient was .85. In sum, it appears that the SD is an attitudinal assessment device that is both reasonably valid and stable and capable of tapping several facets of meaning.

The particular form of the SD used in the present investigation, however, was a modified version which was first used by Nunnally (1961) in his research on attitudes toward the mentally ill (see Appendix D). Nunnally's inventory included 17 scales which were chosen to incorporate the Evaluative, Potency, and Activity factors as well as a fourth factor, labeled Understandability, which Nunnally isolated from ratings of mental health concepts. The following scales were chosen for their high loadings on each of these factors: (1) Evaluative, foolish-wise, intelligent-ignorant, sincere-insincere, warm-cold, clean-dirty, safe-dangerous, valuable-worthless, sick-healthy, and good-bad; (2) Potency, weak-strong, and rugged-delicate; (3) Activity, active-passive, slow-fast, and relaxed-tense; and (4) Understandability, predictable-unpredictable, strange-familiar, and understandable-mysterious.

The scales used in the current investigation followed the standard seven-point format. However, the polarity of the scales was not altered as was done in Nunnally's (1961) earlier research. Nunnally (1969) subsequently reported that subjects easily become confused by numerous alternations in scale polarity. He concluded that reversing the polarity, a procedure designed to prevent subjects from being influenced by ratings made on previous scales, is not worth the price paid in measurement error.

A total score for each of the four factors was calculated by adding the scores of the individual scales comprising the factor. Thus, scores on the Evaluative factor ranged from 9 to 63 and Potency, Activity, and Understandibility score ranges were 2-14, 3-24, and 3-21 respectively.

Employment Questionnaire (EQ). To assess the degree to which subjects might overtly discriminate against the applicant in their hiring practices under various labeling conditions, a series of four questions were asked concerning the applicant's employability (see Appendix E). First, subjects were asked if they would hire the applicant (Yes or No response). They were then asked to rate their degree of comfort with that decision on a seven-point Likert scale ranging from very comfortable to very uncomfortable. Subjects were also asked if they would hire the applicant if there were a number of other qualified applicants applying for the job, and they were subsequently asked to rate their degree of comfort with that decision.

Supplementary Measures.

In addition to the primary dependent measures, two sets of additional data were obtained to assess the degree to which subjects believed the stated purpose of the study and to assess the degree of dangerous subjects associated with the mental disorders described.

Deception Check. As noted above, the true purpose of this study was disguised to prevent subjects from responding in a socially desirable fashion. In order to assess the degree to which this manipulation worked, subjects were given several questions upon completion of the primary dependent measures (see Appendix F). First, they were asked to indicate whether or not they believed deception had been employed (Yes or No response). Next, all subjects who responded affirmatively to the first question were asked to write a brief summary of what they believed the true purpose of the experiment to be.

Dangerousness Ratings. It was speculated before the investigation was run that the disorders evaluated in the study might produce differential social rejection ratings due to differing perceptions of the degree of danger associated with each condition. To allow for analysis of that possibility, all subjects except those in control conditions were given a final 7-point Likert scale on which they were asked to rate the dangerousness of individuals suffering from the disorder portrayed in their respective biographical sketches (see Appendix G). Subjects in the

unlabeled behavioral description conditions rated an abbreviated description of the disorder previously described in their historical sketches, whereas subjects in the labeled groups rated only diagnostic labels. For example, subjects in the unlabeled paranoid schizophrenic condition were asked : "How dangerous are individuals who are highly paranoid and falsely believe others are plotting to harm them?" In contrast, subjects in the labeled paranoid schizophrenic condition were asked: "How dangerous are individuals who suffer from paranoid schizophrenia?".

Procedures

A packet containing a brief description of the study, 1 of 10 possible biographical sketches, and a copy of each dependent measure was randomly distributed to each subject. Participants were first asked to read a cover sheet in which the study was described as an investigation designed to assess the usefulness of various devices in helping employers evaluate job applicants (see Appendix A). The study was portrayed in this fashion in order to minimize demand characteristics which might confound the results if subjects were to know the true purpose of the experiment. Subjects were asked to read the introductory statement to themselves while the experimenter read it aloud.

Participants were then asked to read a biographical sketch of a job applicant. Each subject was given 1 of 10 sketches corresponding to the 10 experimental conditions. Four of the sketches contained descriptions of symptoms commonly exhibited by individuals suffering from paranoid

schizophrenia, a major reactive depression, alcoholism, or an unspecified mental illness (see Appendices H, I, J, & K). For example, the biographical sketch for the paranoid schizophrenic condition contained the following description:

Shortly after he began his job as a salesman, Jim began to experience personal difficulties. He became very suspicious of his friends, co-workers, and family and began to think everyone was against him. At times he thought people he saw on the street were talking about him or following him. Jim became increasingly fearful and withdrawn and began to believe that everyone was part of a plot to harm him. He stopped using his home phone as he feared that the CIA had tapped the line to gather evidence against him. Jim eventually quit his job and received treatment for his problems in a local hospital.

The behavioral description corresponding to the "mental illness" label contained vague Barnun-like statements so that it would not sound like any specific type of mental disorder.

Four additional sketches contained identical behavioral descriptions, but had a sentence affixed to them in which the disorder described was labeled by a psychiatrist. For example, the labeled version of the above behavioral description for paranoid schizophrenia concluded with a sentence indicating that a psychiatrist diagnosed the applicant as a paranoid schizophrenic (enclosed in parentheses in Appendices H, I, J, & K). The remaining two sketches served as controls. The first included most of the same information contained in the above sketches but contained no reference to a previous mental disorder either

by way of describing symptomatic behaviors or by use of a label denoting a mental disorder. The second control was similar to the first but contained a statement in which the applicant was described as an "efficient worker who responds well to stress" (see Appendix L).

After all subjects finished reading their biographical sketches, a 20-minute videotaped segment of a simulated job interview between the applicant and a prospective employer was presented. A Caucasian male actor was paid to serve as the job applicant and was instructed to act like a normal person applying for a job. A male Caucasian actor played the role of an employer and asked the applicant questions. Both actors were blind to the purpose of the investigation and spoke according to a memorized transcript. The transcript (see Appendix M) focused on the applicant's current level of occupational and interpersonal adjustment and portrayed him as a healthy, stable individual.

After viewing the interview, subjects were asked to complete all dependent measures. Before leaving, they were fully debriefed as to the true nature of the experiment.

CHAPTER III

RESULTS

To test the three primary experimental hypotheses, 2X2X5 (gender by label by behavioral description) analyses of variance were performed on raw scores obtained on the Personal Attribute Inventory, the Social Rejection Index, and each of the four factors of the Semantic Differential (Evaluative, Potency, Activity, and Understandability). Newman-Keuls tests were subsequently employed for each scale to examine differences between specific group means.

On the Employment Questionnaire, chi-square tests were employed to analyze data from the first and third items which asked subjects to make dichotomous decisions as to whether they would hire the job applicant. Bonferroni tests were used to assess differences between groups. Scores from the remaining two 7-point Likert scale ratings of confidence in the hiring decisions were examined with a 2X2X5 analyses of variance.

The results of each of these primary analyses are presented below and are followed by data from the deception check and dangerousness rating scales. In most cases, higher scores are reflective of higher levels of social rejection. The one exception is the Employment Questionnaire (items 1 and 3) where higher scores signify

higher frequencies of hiring and are therefore indices of social acceptance. In each ANOVA, the presence of significant effects for factors A (sex of subject), B (labeling), and C (behavioral description) are particularly germane to the experimental hypotheses which predict main effects for each of these variables.

Personal Attribute Inventory (PAI).

A 2X2X5 analysis of variance of subjects' PAI scores revealed no significant main effects or interactions. Table 1 summarizes the ANOVA results, and Table 2 displays means and standard deviations of PAI scores for the 20 experimental groups.

Social Rejection Index.

Analysis of variance of SRI scores revealed significant main effects for sex of subject, $F(1,220)=12.52, p<.001$, and for the behavioral description condition, $F(4, 220)=3.21, p<.05$ (see Table 3). No significant labeling effect was obtained, and there were no significant interactions. Comparisons of group means within the gender main effect indicated that females ($x=18.68, n=120$) were significantly more rejecting than males ($x=16.58, n=120$). Subsequent Newman-Keuls multiple comparisons of groups means within the behavioral description condition (mental illness, $x=18.60, n=48$; major depression, $x=18.31, n=48$; paranoid schizophrenia, $x=18.17, n=48$; alcoholism, $x=17.40, n=48$;

Table 1
Analysis of Variance of Personal Attribute Inventory Scores

Source of Variance	Sum of Squares	df	Mean Square	F	p
Sex of Subject (A)	173.40	1	173.40	1.99	.16
Labeling (B)	17.07	1	17.07	.19	.66
Behavioral Description (C)	473.19	4	118.30	1.36	.82
A X B	4.27	1	4.27	.04	.25
A X C	416.81	4	104.20	1.20	.31
B X C	291.23	4	72.81	.83	.50
A X B X C	69.61	4	17.40	.20	.93
Residual	19092.20	220	86.78		
Total	20537.70	239			

Note: all values of F are non-significant.

Table 2
Summary of Group Means and Standard Deviations
for the Personal Attribute Inventory

		Behavioral Description									
		Paranoid Schizophrenia		Major Depression		Alcoholism		Mental Illness		Control	
		M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)
Male	Labeled	9.00	(10.84)	6.42	(10.44)	10.67	(10.29)	7.25	(8.00)	7.75	(8.18)
	Unlabeled	8.91	(10.20)	10.25	(10.32)	9.41	(10.30)	9.00	(7.20)	7.50	(7.59)
Female	Labeled	11.25	(10.97)	10.41	(10.14)	11.66	(7.83)	11.75	(9.41)	5.83	(8.82)
	Unlabeled	12.50	(8.89)	12.33	(11.09)	6.33	(7.27)	15.00	(9.40)	6.08	(7.20)
\bar{X}		10.42		9.85		9.52		10.75		6.79	

Note: n for all groups = 12.

Table 3
Analysis of Variance of Social Rejection Index Scores

Source of Variance	Sum of Squares	dF	Mean Square	F	p
Sex of Subject (A)	262.50	1	262.50	12.52	.0008***
Labeling (B)	15.50	1	15.50	.74	.60
Behavioral Description (C)	269.39	4	67.35	3.21	.014*
A X B	.10	1	.10	.00	.94
A X C	101.64	4	25.41	1.21	.31
B X C	50.73	4	12.68	.60	.66
A X B X C	88.54	4	22.14	1.05	.38
Residual	4611.58	220	20.96		
Total	5400.00	239			

and control, $x=15.67$, $n=48$) indicated that subjects exposed to the mental illness, major depression, and paranoid schizophrenia description conditions were significantly more rejecting than subjects in the control conditions. No significant mean differences were obtained among the four types of disorders portrayed. Table 4 displays SRI means and standard deviations for the 20 experimental groups and presents the overall means (bottom row) for each of the five behavioral description conditions.

Semantic Differential (Evaluative Factor).

A 2X2X5 analysis of variance of Evaluative factor scores revealed no significant main effects or interactions. However, the behavioral description main effect approached significance, $F(4,220)=2.07$, $p=.08$. Nevertheless, subsequent Newman-Keuls pairwise comparisons of groups means within the behavioral description condition yielded no significant differences. Table 5 summarizes ANOVA results for the SRI, and Table 6 displays groups means and standard deviations as well as overall means (bottom row) for each of the behavioral description conditions.

Semantic Differential (Potency Factor).

Analysis of variance of Potency factor scores revealed no significant differences. However, the F-ratios for the gender ($F(1,220)=2.65$, $p=.10$) and the behavioral description ($F(4,220)=2.15$, $p=.07$) conditions approached significance.

Table 4
Summary of Group Means and Standard Deviations
for Social Rejection Index Scores

		Behavioral Description									
		Paranoid Schizophrenia		Major Depression		Alcoholism		Mental Illness		Control	
		M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)
Male	Labeled	16.67	(4.89)	18.00	(4.11)	16.25	(4.22)	16.74	(4.67)	16.42	(5.16)
	Unlabeled	17.17	(4.97)	16.25	(4.73)	15.92	(4.03)	17.08	(4.58)	15.33	(3.33)
Female	Labeled	20.42	(5.47)	18.75	(4.20)	20.50	(4.19)	19.58	(4.40)	15.50	(4.50)
	Unlabeled	18.42	(4.48)	20.25	(5.56)	16.92	(3.85)	21.00	(4.76)	15.42	(3.93)
\bar{X}		18.17		18.31		17.40		18.60		15.67	

Note: n for all groups = 12.

Table 5

Analysis of Variance for Semantic Differential (Evaluative Factor) Scores

Source of Variance	Sum of Squares	dF	Mean Square	F	p
Sex of Subject (A)	121.84	1	121.84	1.77	.18
Labeling (B)	37.60	1	37.60	.54	.53
Behavioral Description (C)	571.57	4	142.89	2.07	.08
A X B	2.60	1	2.60	.03	.84
A X C	406.77	4	101.69	1.48	.21
B X C	70.08	4	17.52	.25	.90
A X B X C	105.42	4	26.35	.38	.82
Residual	15121.40	220	68.73		
Total	16437.30	239			

Table 6

Summary of Means and Standard Deviations
for Semantic Differential (Evaluative Factor) Scores

		Behavioral Description									
		Paranoid Schizophrenia		Major Depression		Alcoholism		Mental Illness		Control	
		M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)
Male	Labeled	29.58	(9.10)	30.58	(11.02)	27.67	(7.21)	29.00	(5.95)	27.17	(6.62)
	Unlabeled	28.33	(6.54)	28.00	(8.14)	28.17	(7.00)	27.75	(7.36)	28.83	(7.04)
Female	Labeled	32.91	(10.47)	29.83	(9.17)	30.58	(6.19)	33.50	(8.23)	25.33	(7.68)
	Unlabeled	30.66	(10.99)	30.17	(10.98)	26.41	(6.75)	34.08	(6.57)	25.83	(9.38)
\bar{X}		30.38		29.65		28.21		31.08		26.79	

Note: n = 12 for all groups.

Although subsequent Newman-Keuls tests yielded no significant group mean differences, the pattern of trends observed (i.e., effects due to sex of subject and behavioral descriptions, but not labeling) parallels the results reported for the SRI. Table 7 summarizes ANOVA results and Table 8 contains group means and standard deviations for Potency factor scores and overall means for each behavioral description condition.

Semantic Differential (Activity Factor).

Analysis of variance of Activity factor scores yielded a significant main effect for the behavioral description condition ($F(4,220)=4.69$, $p<.01$). Subsequent Newman-Keuls comparisons of groups means within the behavioral description factor (major depression, $x=12.90$, $n=48$; mental illness, $x=12.52$, $n=48$; paranoid schizophrenia, $x=12.42$, $n=48$; alcoholism, $x=11.56$, $n=48$; and control, $x=10.45$, $n=48$) indicated that subjects exposed to applicant histories containing descriptions of major depression, mental illness, or paranoid schizophrenia produce significantly higher Activity factor scores than subjects in the control condition. That is, relative to controls, subjects in those three groups rated the applicant as being less energetic and more passive. No significant differences in mean ratings were obtained among the four disorders. Refer to Table 9 for a summary of the ANOVA results and Table 10 for a summary of group means and standard deviations for Activity

Table 7

Analysis of Variance for Semantic Differential (Potency Factor) Scores

Source of Variance	Sum of Squares	dF	Mean Square	F	p
Sex of Subject (A)	14.01	1	14.01	2.65	.10
Labeling (B)	4.27	1	4.26	.80	.63
Behavioral Description (C)	45.43	4	11.36	2.15	.07
A X B	1.35	1	1.35	.25	.62
A X C	10.57	4	2.64	.50	.74
B X C	24.90	4	6.23	1.18	.32
A X B X C	16.73	4	4.18	.79	.53
Residual	1160.67	220	5.28		
Total	1277.93	239			

Table 8
Summary of Means and Standard Deviations
for Semantic Differential (Potency Factor) Scores

		Behavioral Description									
		Paranoid Schizophrenia		Major Depression		Alcoholism		Mental Illness		Control	
		M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)
Male	Labeled	8.00	(1.54)	8.42	(2.75)	8.42	(2.54)	8.67	(1.45)	7.17	(2.32)
	Unlabeled	8.25	(1.42)	8.25	(2.98)	7.17	(1.99)	7.42	(1.50)	7.50	(2.07)
Female	Labeled	8.17	(2.17)	7.17	(2.78)	7.92	(2.10)	7.58	(2.35)	6.67	(2.10)
	Unlabeled	8.08	(1.73)	7.58	(3.05)	6.08	(1.56)	8.58	(3.15)	6.58	(2.94)
\bar{X}		8.13		7.85		7.40		8.06		6.97	

Note: n = 12 for all groups.

Table 9

Analysis of Variance for Semantic Differential (Activity Factor) Scores

Source of Variance	Sum of Squares	df	Mean Square	F	p
Sex of Subject (A)	13.54	1	13.54	1.39	.24
Labeling (B)	16.54	1	16.54	1.69	.19
Behavioral Description (C)	182.94	4	45.73	4.69	.0015**
A X B	1.84	1	11.84	.18	.67
A X C	47.53	4	11.88	1.22	.30
B X C	72.94	4	18.24	1.87	.12
A X B X C	72.39	4	18.10	1.85	.12
Residual	2143.08	220	9.74		
Total	2550.80	239			

Table 10

Summary of Means and Standard Deviations
for Semantic Differential (Activity Factor) Scores

		Behavioral Description									
		Paranoid Schizophrenia		Major Depression		Alcoholism		Mental Illness		Control	
		M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)
Male	Labeled	12.25	(2.33)	12.58	(3.29)	11.58	(3.37)	10.75	(2.83)	9.75	(3.52)
	Unlabeled	12.33	(3.92)	12.67	(3.11)	12.00	(3.98)	12.17	(3.30)	11.25	(3.05)
Female	Labeled	12.17	(3.21)	11.83	(2.48)	12.92	(3.03)	13.92	(3.34)	9.33	(3.05)
	Unlabeled	12.92	(2.61)	14.50	(3.61)	9.75	(2.67)	13.25	(3.07)	11.50	(2.43)
\bar{X}		12.41		12.90		11.56		12.52		10.45	

Note: n = 12 for all groups.

factor scores.

Semantic Differential (Understandability Factor).

As shown in Table 11, analysis of variance of subjects' scores on the Understandability factor produced a main effect for behavioral descriptions ($F(1,220)=3.16$, $p<.01$) and a significant sex by behavioral description interaction ($F(4,220)=3.00$, $p<.05$). In addition, the F-ratio for the sex of subject main effect approached significance ($F(1,220)=2.59$, $p=.10$). Newman-Keuls multiple comparisons of group means within the behavioral description main effect revealed only one significant difference among pairs, with the mental illness condition receiving significantly higher Understandability ratings ($x=12.88$, $n=48$) than the control condition ($x=10.56$, $n=48$). Table 12 presents the means and standard deviations of Understandability ratings for each of the 20 experimental groups and displays overall group means (bottom row) for each of the behavioral description conditions.

Subsequent Newman-Keuls tests of the 10 means comprising the sex by disorder (A X C) interaction indicated that that effect was primarily produced by the female group mean for the "mental illness" behavioral description ($x=14.38$, $n=24$) which was significantly greater than three of the remaining four female groups (paranoid schizophrenia, $x=11.79$, $n=24$; alcoholism, $x=11.33$, $n=24$; and control, $x=9.96$, $n=24$) and all five male group means (paranoid

Table 11
Analysis of Variance for Semantic Differential
(Understandability Factor) Scores

Source of Variance	Sum of Squares	dF	Mean Square	F	p
Sex of Subject (A)	27.34	1	27.33	2.59	.10
Labeling (B)	.10	1	.10	.01	.92
Behavioral Description (C)	132.93	4	33.23	3.16	.01**
A X B	.20	1	.20	.01	.88
A X C	126.27	4	31.57	3.00	.02*
B X C	50.58	4	12.64	1.20	.31
A X B X C	69.65	4	17.41	1.65	.16
Residual	2313.92	220	10.52		
Total	2721.00	239			

Table 12
Summary of Means and Standard Deviations
for Semantic Differential (Understandability Factor) Scores

		Behavioral Description									
		Paranoid Schizophrenia		Major Depression		Alcoholism		Mental Illness		Control	
		M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)
Male	Labeled	12.08	(2.99)	11.58	(3.75)	11.17	(3.71)	10.25	(2.80)	11.83	(2.69)
	Unlabeled	11.00	(2.63)	10.58	(4.06)	11.83	(3.16)	12.50	(3.58)	10.50	(2.43)
Female	Labeled	11.33	(2.57)	13.08	(3.68)	12.50	(3.15)	13.92	(3.29)	9.17	(3.56)
	Unlabeled	12.25	(3.52)	12.08	(2.19)	10.17	(3.33)	14.83	(3.38)	10.75	(3.62)
\bar{X}		11.67		11.83		11.42		12.88		10.56	

Note: n = 12 for all groups.

schizophrenia, $x=11.54$, $n=24$; major depression, $x=11.08$, $n=24$; alcoholism, $x=11.50$, $n=24$; mental illness, $x=11.38$, $n=24$; and control, $x=11.17$, $n=24$). Thus, this interaction suggests that the difference between Understandability ratings of males and females varied as a function of the type of behavioral description employed, with no significant differences being apparent except under the mental illness description where females produced significantly higher ratings (i.e., saw the applicant as more mysterious) than males. Refer to Figure 1 for an illustration of this interaction.

Employment Questionnaire. Chi-square tests were used to analyze frequency data generated by the first and third items of the Employment Questionnaire which asked subjects first to indicate whether they would hire the applicant, and then to state whether they would hire the applicant if a number of other qualified applicants were applying for the same job. On question 1, a significant main effect was obtained for subject gender ($\chi^2=10.5$, $df=1$, $p<.01$), with females offering significantly fewer jobs than males. In addition, a marginally significant effect was obtained for the behavioral description condition ($\chi^2=8.47$, $df=4$, $p<.10$).

Chi-square tests of all possible pairs within that behavioral description main effect were subsequently computed. When adjusted via the Bonferroni procedure to guard against familywise Type I error, these tests revealed

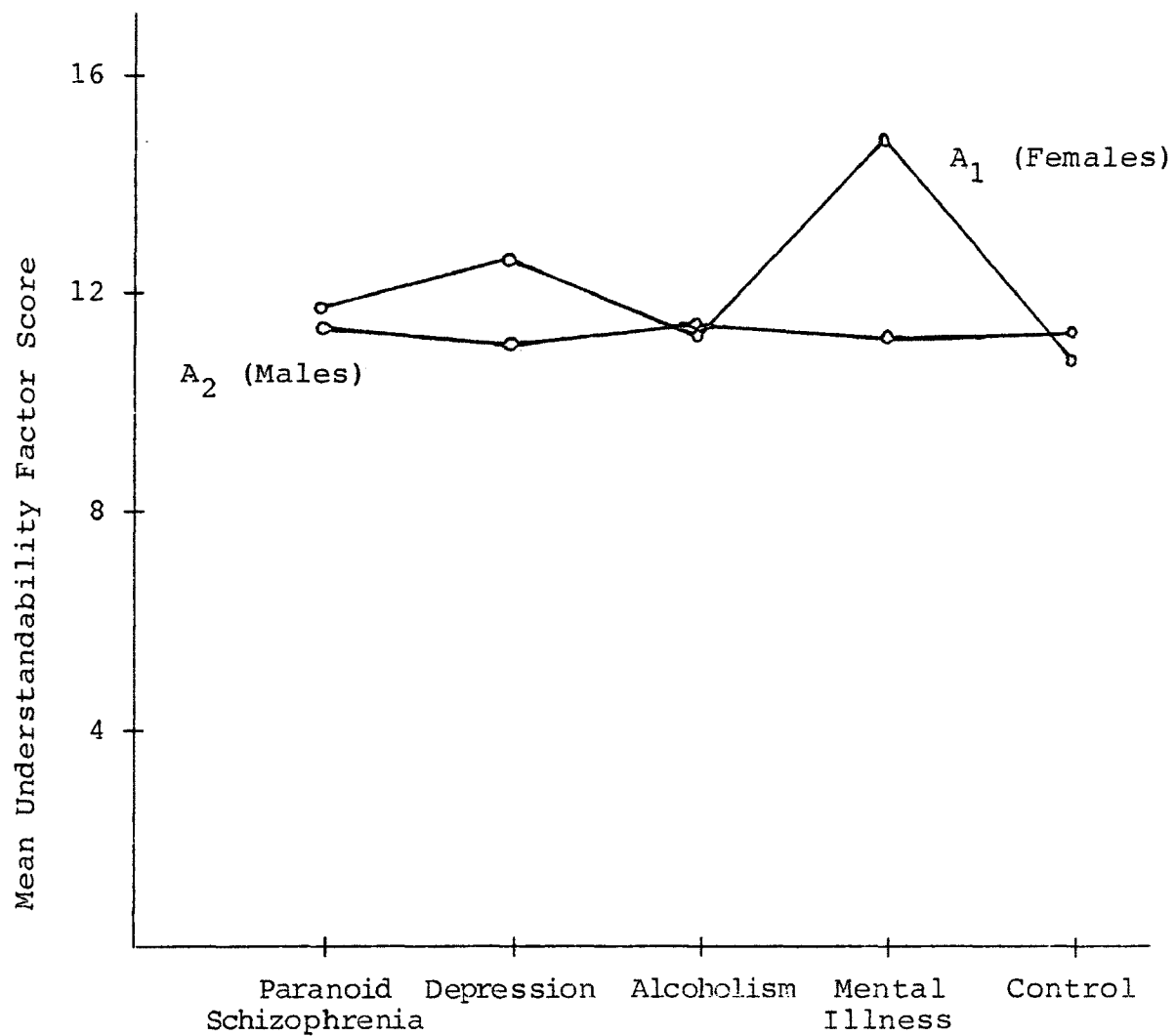


Figure 1

Graphical Representation of the Sex by Behavioral Description
Interaction for the Understandability Factor

only one significant difference among pairs, with subjects in the mental illness behavioral description group offering significantly fewer jobs than subjects in the control condition ($\bar{X} = 8.3$, $df=1$, $p<.05$). Consistent with the results of the above inventories, no labeling effect was obtained. Moreover, no significant interactions among the factors were found after adjustments for family error were made with the Bonferroni procedure.

No significant main effects or interactions were obtained for the third question of the Employment Questionnaire. This lack of significant differences among groups is probably best explained by a consistent tendency for all groups (including the controls) to avoid hiring the applicant when he was compared with other qualified applicants. That is, the applicant portrayed on the videotape was hired with low frequency irregardless of whether or not he was portrayed as a former mental patient. The overall low frequency of job offerings under this condition, therefore, may have caused a "floor" effect which obfuscated possible differences among groups.

Analyses of variance of raw data generated from questions 2 and 4, which consisted of 7-point Likert scale ratings of confidence in the hiring decisions made in questions 1 and 3, revealed no significant effects. This finding suggests that subjects' confidence in their hiring decisions was not significantly effected by their gender or by the labeling or behavioral description experimental

conditions. An ANOVA summary table for the ratings on question 2 is presented in Table 13, and means and standard deviations are displayed in Table 14. Tables 15 and 16 contain corresponding data from question 4.

Dangerousness Ratings.

As noted above, half of the males and half of the females used to generate dangerousness scores rated the dangerousness of the four disorders when they were portrayed with a brief behavioral description, and half when they were designated with a diagnostic label only. Moreover, no subjects in control groups were asked to make dangerousness ratings. Therefore, a 2 (sex of subject) by 2 (mode of disorder portrayal) by 4 (type of disorder) ANOVA was used to evaluate subject's dangerousness ratings.

No significant disorder effect was obtained, suggesting that subjects did not associate differing degrees of dangerousness with the four disorders. Interestingly, however, a significant main effect was obtained for the manner in which each syndrome was portrayed (i.e., label versus symptom description), $F(1,176)=9.85$, $p<.01$. Comparisons of group means within that main effect indicated that the groups of subjects who rated the dangerousness of hypothetical individuals exhibiting clusters of behaviors corresponding to the four types of disorders used in the study rated the applicant as more dangerous ($x=5.01$, $n=96$) than subjects who were asked to evaluate the dangerousness

Table 13
Analysis of Variance of Employment Questionnaire (Item 2)

Source of Variance	Sum of Squares	dF	Mean Square	F	p
Sex of Subject (A)	.15	1	.15	.07	.78
Labeling (B)	4.27	1	4.27	2.06	.15
Behavioral Description (C)	8.54	4	2.13	1.03	.39
A X B	.02	1	.02	.60	.92
A X C	1.80	4	.45	.21	.93
B X C	4.85	4	1.21	.58	.68
A X B X C	8.69	4	2.17	1.05	.38
Residual	455.00	220	2.07		
Total	483.33	239			

Table 14

Summary of Group Means and Standard Deviations
for Employment Questionnaire (Item 2) Scores

		Behavioral Description									
		Paranoid Schizophrenia		Major Depression		Alcoholism		Mental Illness		Control	
		M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)
Male	Labeled	5.16	(1.33)	5.00	(1.70)	4.75	(1.81)	4.92	(1.67)	5.50	(1.45)
	Unlabeled	5.41	(1.51)	5.42	(1.44)	5.67	(1.23)	4.83	(1.53)	5.25	(1.22)
Female	Labeled	5.25	(1.42)	5.33	(.65)	5.00	(1.41)	4.25	(1.60)	5.17	(1.27)
	Unlabeled	4.66	(1.61)	5.50	(1.08)	5.33	(1.44)	5.33	(1.23)	5.58	(1.68)
\bar{X}		5.13		5.31		5.19		4.83		5.38	

Note: n = 12 for all groups.

Table 15
Analysis of Variance of Employment Questionnaire (Item 4)

Source of Variance	Sum of Squares	df	Mean Square	F	p
Sex of Subject (A)	.00	1	.00	.00	.96
Labeling (B)	.70	1	.70	.34	.57
Behavioral Description (C)	6.23	4	1.56	.75	.55
A X B	.20	1	.20	.10	.75
A X C	2.68	4	.67	.32	.86
B X C	6.90	4	1.72	.84	.50
A X B X C	8.65	4	2.16	1.05	.38
Residual	451.42	220	2.05		
Total	476.80	239			

Table 16

Summary of Group Means and Standard Deviations
for Employment Questionnaire (Item 4) Scores

		Behavioral Description									
		Paranoid Schizophrenia		Major Depression		Alcoholism		Mental Illness		Control	
		M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)
Male	Labeled	5.25	(1.36)	5.17	(1.85)	5.08	(1.38)	4.58	(1.88)	5.50	(1.38)
	Unlabeled	4.91	(1.38)	5.17	(1.53)	5.08	(1.38)	4.83	(1.47)	4.75	(1.29)
Female	Labeled	5.41	(1.17)	5.50	(1.00)	5.17	(1.40)	4.42	(2.02)	4.75	(.96)
	Unlabeled	5.41	(1.08)	4.66	(1.83)	4.50	(1.50)	5.25	(1.28)	5.17	(1.03)
\bar{X}		5.25		5.13		4.96		4.77		5.04	

Note: n = 12 for all groups.

of individuals suffering from the same disorders but designated with a diagnostic label ($x = 4.35$, $n = 96$). That is, symptomatic descriptions of various disorders generated higher ratings of dangerousness than labels for those descriptions. Refer to Table 17 for a summary of the ANOVA results, and to Table 18 for a display of the mean dangerousness ratings and standard deviations for all experimental groups and overall mean dangerousness ratings (bottom row) for each of the four disorders.

Deception Check.

Thirty-seven of the 240 subjects used in this investigation indicated that they thought deception had been employed. However, when these individuals were subsequently asked to describe what they believed the objective of the study to be, only three gave correct responses. These findings suggest that the vast majority of subjects believed in the stated purpose of the investigation, and that the vast majority of subjects who did suspect deception did not deduce the true purpose of the experiment. Thus, it can be concluded that the deception employed in the study was generally effective.

Table 17
Analysis of Variance of Dangerousness Ratings

Source of Variance	Sum of Squares	df	Mean Square	F	p
Sex of Subject (A)	.02	1	.02	.01	.91
Mode of Disorder Portrayal (B)	20.02	1	20.02	9.85	.002**
Type of Disorder (C)	4.63	3	1.54	.75	.52
A X B	2.08	1	2.08	1.02	.31
A X C	7.69	3	2.56	1.26	.29
B X C	9.19	3	3.06	1.50	.21
A X B X C	2.13	3	.71	.34	.79
Residual	357.50	176	2.03		
Total	403.25	191			

Table 18

Summary of Group Means and Standard Deviations for Dangerousness Ratings

		Type of Disorder							
		Paranoid Schizophrenia		Major Depression		Alcoholism		Mental Illness	
		M	(S.D.)	M	(S.D.)	M	(S.D.)	M	(S.D.)
Male	Label	4.42	(1.30)	4.33	(1.15)	4.75	(1.86)	3.58	(.90)
	Symptom Description	5.50	(1.38)	4.83	(1.80)	5.25	(1.28)	4.91	(.79)
Female	Label	4.75	(1.60)	4.58	(1.44)	4.50	(1.88)	4.00	(1.20)
	Symptom Description	4.91	(1.38)	5.08	(1.23)	4.25	(1.42)	5.33	(1.61)
\bar{X}		4.90		4.70		4.69		4.46	

Note: n = 12 for all groups.

CHAPTER IV

DISCUSSION

This section will begin with a discussion of the evidence obtained for each experimental hypothesis. That exposition will be followed with a discussion of the implications of those findings for labeling theory. Finally, the chapter will conclude with suggestions for future research on public attitudes toward the mentally ill.

Summary and Interpretation of Results.

The three principle hypotheses of this investigation predicted that all three independent manipulations (labeling, behavioral descriptions, and subject gender) would yield significant main effects across all dependent measures. The results, however, failed to support the first hypothesis. That is, the presence of a diagnostic label had no significant influence on the manner in which subjects evaluated the job applicant on any of the attitudinal or social rejection inventories used in the study. Labeling also failed to differentially influence subjects' hiring decisions. Cumulatively, then, the results suggest that the diagnostic labels had no important influence on the manner in which subjects evaluated the applicant, on the degree to which they saw him as desirable for common social

encounters, or on the extent to which they saw him as a competent potential employee. These findings have important implications for labeling theory which are discussed below.

The second hypothesis received the most consistent support from the data as significant effects or nonsignificant trends due to behavioral descriptions were obtained across all the dependent measures except the Personal Attribute Inventory. Data from the four factors of the Semantic Differential suggest that a person with a previous history of mental disorder is likely to be seen as less positive, less active and energetic, less powerful, and more mysterious than a person with identical attributes but no history of psychological difficulties. Moreover, results from the Social Rejection Index suggest that former mental patients are likely to be viewed as less appealing in a variety of social roles (i.e., marital partners, babysitters, employers, employees, politicians, and club members). Finally, the marginally significant trend obtained on the first employment decision suggests a possible tendency toward discrimination of former patients in the job market. Taken together, these findings support the conclusion that a history of at least some abnormal behavioral syndromes commonly designated as mental disorders can lead to enduring stigmatization. That conclusion is consistent with previous investigations which have pointed to the continued presence of negative attitudes toward the mentally ill in this society (e.g., Brockman et al., 1979;

Olmsted & Durham, 1979).

The magnitude of the stigmatization observed in this study varied somewhat across the types of disorders evaluated. Multiple comparisons revealed that the abnormal behavioral descriptions received higher social rejection ratings than controls on most measures but did not differ significantly from each other on any measure. However, the types of abnormal conditions which were rated greater than controls varied from inventory to inventory. The mental illness description received higher rejection ratings than controls on three attitude inventories and the first employment question; the major depression and paranoid schizophrenic conditions produced higher ratings on two inventories; and the alcoholic condition did not significantly differ from controls on any measure. Hence, the mixture of Barnum-like statements comprising the non-specific "mental illness" condition generated the most consistently negative reactions but was closely followed by the paranoid schizophrenic and major depression conditions. It is unclear why these three conditions consistently generated more rejection than the alcoholic condition. Although it might be speculated that the alcoholic condition was seen as less dangerous, the lack of significant differences in ratings of dangerousness across the four syndromes does not support that hypothesis. It may be that less stigma is attached to excessive drinking since drinking itself is a common, socially acceptable, behavior. In

contrast, some of the behaviors depicted in the major depression, paranoid schizophrenic, and mental illness descriptions may have seemed more bizarre.

The third hypothesis of this investigation predicted significant effects due to subject gender. It was partially supported by the data as significant sex effects were obtained on the SRI and the first employment question. On both measures, females were more rejecting than males. Thus, the data suggest that females are likely to respond less favorably to former male patients than males.

Possible reasons for the observed sex effects are not clear. A reasonable explanation is that females tend to view former male mental patients as more threatening than males. Unfortunately, there is little research available to help clarify that hypothesis as few labeling studies have systematically manipulated the sex of subjects or the sex of the former patient to assess the degree to which ratings vary as a function of subject and/or patient gender. Moreover, the few available studies in this area have not yet fully addressed all aspects of the gender question. A study reported by Phillips (1968), for example, examined the reactions of female subjects to male and female individuals who were portrayed as former mental patients but exhibited nearly identical behavior. The results indicated that males were much more strongly rejected than females. Unfortunately, the fact that only females were used as subjects makes it impossible to compare male and female

subjects on their respective attitudes toward male and female applicants.

A similar interpretive problem resulted from a series of three studies reported by Farina, Felner, and Boudreau (1973). In the first study, female department store workers showed no discrimination toward female job applicants described as former patients. This finding was replicated in a second study which was conducted in a Veterans Administration hospital. However, in a third study which used the same experimental paradigm, males were much more rejecting of a male applicant when he was portrayed as a former patient than when he was not. Taken together, these findings may suggest that females are more tolerant of ex-mental patients than males. However, it should first be noted that males in this series of studies responded only to females, and females reacted only to other females. It is therefore possible that the tolerance shown by females would not have been present had they evaluated a male job applicant.

Thus, while the results of the current investigation and similar studies which have looked at gender effects suggest that the genders of both subjects and ex-patients are important influences on the acceptance granted former patients, they do not clearly indicated how the sex of subjects, patients, or the joint influence of both account for observed effects. In order for this issue to be clarified, research addressing how both males and females

respond to both male and female ex-patients is needed. The current experimental paradigm could be extended to do just that by including a videotape of a female job applicant and having groups of men and women respond to both the male and female applicants.

A final finding worthy of mention from the current investigation concerns the sex by behavior interaction observed on the Understandability factor. As noted above, that interaction was primarily produced by the high mean ratings of the females in the mental illness behavioral description. Females in the other four behavioral description conditions apparently saw the applicant as understandable as their male counterparts, whereas females in the mental illness condition saw the applicant as far more mysterious than males. This finding is difficult to account for as no clear reason seems apparent for females to see one form of disorder as less understandable than males when they view other disorders in a very similar fashion. Perhaps females simply find vaguely described problems like those portrayed in the mental illness condition as more ambiguous than males. Irregardless of how it is explained, this finding has important implications for attitudinal research. It indicates that attitudes toward former mental patients are not isomorphic but can vary with the sex of the person doing the evaluating as well as with the type of disorder being evaluated. Future research needs to more fully address the independent and interactive influence of

both variables.

To summarize, the findings of the current investigation supported the second and third hypotheses, which predicted main effects for behavioral descriptions and subject gender, but yielded no support for the first hypothesis which predicted significant labeling effects. This pattern of results has important implications for labeling theory.

Implications for Labeling Theory.

The results obtained across the first two independent variables have the strongest implications for labeling theory. Specifically, the presence of significant effects for the behavioral description manipulation, coupled with the total lack of effects for the labeling condition, challenges a basic assumption of the labeling perspective. Labeling theory posits that the process of labeling deviant behavior produces lasting stigmatization, while the deviant behavior itself is of little importance and will be transitory if not publicly labeled (Scheff, 1966). Thus, the results of this investigation run directly opposite to what would be predicted on the basis of labeling theory. The data suggest that deviant behaviors, not the labels applied to those behaviors, are responsible for producing the social rejection experienced by mental patients.

These findings are highly consistent with results of several other previously cited experimental investigations which have compared public reactions to labels of mental illness to disturbed behavior itself and found that the behaviors, not the labels evoked negative responses (e.g., Bentz & Edgerton, 1971 ; Kirk, 1974; Loeb et al., 1968; Lehman et al., 1976). Moreover, it should be noted that the design of the current study addressed two criticisms that had previously been directed toward those other investigations (Loman & Larkin, 1976). First, it minimized demand characteristics by disguising the purpose of the experiment; and, secondly, it more realistically simulated real life conditions by having subjects respond to a live stimulus person interacting in a relevant social context rather than simply having them rate written vignettes describing abnormal conditions. Thus, the current findings both support previous findings and challenge several alternate explanations previously used to discount those results. Taken together, the results of these investigations suggest that the labeling process, a central part of Scheff's theory, plays an insignificant role in the perpetuation of mental disorders through social stigmatization.

However, there are several limitations of the current study which suggest that caution needs to be taken in drawing definitive conclusions about labeling theory on the basis of the results generated. First, the labeling process

employed in this investigation took place through a single written descriptive statement. Although labeling theory certainly stresses the act of labeling as a primary event in the process of becoming a stabilized deviant, it is also concerned with a series of social interactions involving labeled individuals which eventually lock them into deviant roles.

Second, this study did not present labels independently of any other potentially stigmatizing stimulus information. That is, all labels were presented along with deviant behavioral descriptions. Thus, there is no way to assess the degree to which the labels used would evoke negative reactions in the absence of other negative stimuli. This factor is not trivial as many studies which have simply asked subjects to report their reactions to a deviant label (e.g., Nunnally, 1961) have found that labels do elicit negative stereotypes. Moreover, in some social situations, people are designated with a label and little other relevant information. In those cases, the label may provide the primary basis on which inferences are made about others. Nevertheless, the thrust of labeling theory rests with its tenets regarding the role of labeling in relation to overt behavior. That is, the core of the theory does not depend on the labels themselves, but with their role in determining how people will interpret and respond to norm-violating behavior. In that respect, the results of this study are highly inconsistent with the labeling perspective as they

show that the influence of labeling is negligible relative to the impact of abnormal behavior itself.

Further, the results obtained from the supplementary dangerousness scales, in which subjects rated the degree of dangerousness associated with syndromes portrayed with either brief descriptions of abnormal behavior or diagnostic labels, showed that the behavioral descriptions yielded significantly higher ratings of dangerousness. This finding suggests that diagnostic labels may engender less social stigma than aberrant behaviors even when they are presented totally independently of the deviant behavior. That conclusion is also inconsistent with labeling theory which postulates that behaviors are generally of little significance unless they are labeled.

A third factor which limits the generality of the conclusions to be drawn stems from the use of college students as subjects. There is ample evidence indicating that the results obtained from the college population on studies dealing with attitudes toward the mentally ill cannot be applied without restriction to groups with lower levels of education and socioeconomic status (Gove & Howell, 1974; Schwartz, Myers, & Astrachan, 1974). It is possible, therefore, that a labeling effect may have been obtained with subjects from lower socioeconomic groups who traditionally have held more negative attitudes toward the mentally ill (Rabkin, 1980).

A fourth factor limiting the degree to which the results of this investigation can be unequivocally taken as evidence against labeling theory relates to the extent and the duration of "normal" social/occupational functioning exhibited by former patients following their mental illness episodes. It is important to remember that the stimulus person presented in the videotape of this study was made to appear as an average job applicant with no current behavioral abnormalities. Moreover, even in those conditions in which the applicant was described as a former mental patient, material was also presented in both the historical sketch and the interview which portrayed sound, if not superior, post-treatment functioning of several years duration in common social, marital, and occupational roles. All these factors may have attenuated a labeling effect that may have been present under less optimal conditions. Thus, while the results of this investigation suggest that labeling has little influence on the evaluations of ex-patients who exhibit normal social functioning for several years following treatment, they do not preclude the possible influence on labeling on attitudes toward patients who have been treated more recently and/or continue to exhibit abnormal behavior.

Additional research is needed to assess the effects of labeling over varying amounts of time after treatment and with varying mixtures of adaptive and maladaptive post-treatment behaviors. However, it is likely that such

research will find that the effects of labeling, if present at all, are either short-lived or are trivial in relation to abnormal behavior itself. That conclusion was reached by Gove and Fain (1973) who interviewed ex-patients and found that a substantial portion of their sample were initially somewhat embarrassed after being discharged from a mental hospital but did not perceive any negative long-term social consequences. Similarly, the results of this study point to the absence of any negative long-term influences due to diagnostic labels.

To summarize, several factors inherent in the format of the current investigation and with the subject population employed argue for cautious interpretation of the results obtained. Nevertheless, it appears reasonable to accept this study as an additional piece of evidence against the labeling theory of mental illness. At a minimum, the results suggest that the purported stigmatizing effect of labels are not long lasting and are of minimal importance relative to overt behavior. If additional research verifies that conclusion, labeling theory may need to be substantially modified, if not abandoned.

Even if labeling theory ultimately fails to obtain adequate empirical validation as a viable explanation for the etiology or the course of mental disorders, it will still have served a very useful function by directing attention to the social factors which influence the treatment of individuals suffering from psychological

problems. It has challenged proponents of the medical model to look at the role of social forces in the successful management of mental disorders rather than working exclusively within the individual. Even Gove (1976), one of the most outspoken critics of labeling theory, agrees that the social processes described by labeling theorists are important.

Moreover, it should be noted that this investigation in some ways supported the presence of the stigmatizing processes so strongly stressed by labeling theorists. Specifically, the findings indicated that a history of mental illness lead to social rejection even after several years of superior post-treatment functioning. Although the origin of that rejection was apparently due to abnormal behaviors rather than labels, the presence of the stigma is important nonetheless. It indicates that people continue to hold negative attitudes toward individuals with a history of mental illness. Thus, this investigation supports the labeling theory position with regard to the presence of negative attitudes but challenges their contention that diagnostic labels are primarily responsible for those attitudes.

The continued presence of negative attitudes toward ex-mental patients suggested by this research highlights the need for continued research on those attitudes and on means for modifying them so as to minimize the hardship incurred by recovering patients. The findings of the present study

suggest several possible directions for subsequent attitudinal research. This chapter will be concluded with those recommendations.

Suggestions for Future Attitudinal Research.

The current study found that a history of mental illness could have an enduring effect on people's attitudes toward former patients. More specifically, the job applicant portrayed in the study was evaluated more negatively when he was portrayed as previously suffering from a non-specific mental illness, paranoid schizophrenia, or a major depressive episode. It is important to note that all three of these conditions contained descriptions of severely disturbed behavior. Therefore, the results obtained cannot be readily generalized across other types of psychological problems. It is possible that a history of treatment for a milder form of psychological problem would not have produced the lasting stigmatization observed in this study. Future research needs to more fully address attitudes toward the wide variety of problems commonly observed in mental health practice. The degree of stigma associated with treatment for marital and family problems, for example, has yet to be evaluated empirically.

A second recommendation relates to the measurement of attitudes toward the mentally ill. As noted previously, most attitudinal studies have used instruments that were developed for the study and have little or no data

documenting their reliability or validity (Brockman et al., 1979). This state of affairs makes it difficult to assess the degree to which the findings obtained in any given study are merely an artifact of the measurement instruments used. That fact is highlighted by the results of the current study which varied widely across the dependent measures employed. For example, the Personal Attribute Inventory yielded no significant effects whereas most of the other measures yielded one or more significant findings. Thus, the conclusions drawn from this study would have differed had the PAI been the only dependent measure used. Clearly, there is a need for the development of attitudinal scales with demonstrated reliability and validity. In the interim, attitudinal studies should more consistently follow the advice of Brockman et al. (1979) and Rabkin (1974) and use multiple assessment devices to offset the potentially spurious conclusions made on the basis of only one instrument and to tap more fully the multifaceted dimensions of attitudes.

A third area in need of future work concerns the relationship between negative attitudes toward the mentally ill and overt discriminatory or punitive behavior directed toward them. That is, given the notoriously low correlation between attitudes and overt behavior (Rabkin, 1980), prudent practice suggests the need for valid demonstrations that negative attitudes actually result in overt social rejection. In many cases, the reported differences in

attitudes toward normal individuals versus those with a history of mental illness may be statistically significant, but the magnitude of the difference may be so small that it has little practical importance with regard to how subjects actually treat former mental patients. In the present study, for example, group means which were significantly different in a statistical sense seldom differed by more than a few units on any scale.

Clearly, a great deal of research is needed to determine the status of current public attitudes toward the mentally ill and to develop means for modifying those attitudes so as to facilitate the recovery of individuals suffering from psychological problems. However, as this research is undertaken, it will be important to ask the question: "How should the public feel about the mentally ill?". It is probably unrealistic to expect that people will ever react to mental patients as they do to "normal" individuals. Emotionally disturbed people are often unpleasant to be around and exhibit embarrassing or unpredictable behavior. Moreover, many former patients experience a relapse of symptoms after a period of recovery and may therefore be less dependable than the average person. As Nunnally (1961) points out, the only realistic hope is that people will come to devalue the mentally ill less. The results of this study and findings from previous research suggest that the public's devaluation of the mentally ill is unreasonably extreme.

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APPENDIX A
INTRODUCTORY INFORMATION

This study is designed to evaluate how helpful different devices are for employers in making judgements about job applicants. You will first be asked to read an introductory sketch concerning a job applicant's history. You will then be shown a simulated videotape of the applicant in a job interview with an employer, and you will subsequently be asked to fill out several forms designed to assess your reactions to the applicant. While reading the sketch and viewing the tape, act as if you were an employer who had to attend to all available information in order to reach a decision as to whether or not the applicant should be hired.

Please begin by reading the sketch of Jim Anderson, the job applicant, on the following page.

DIRECTIONS: This instrument contains a list of adjectives. Read through the list and select exactly 30 words which you think best describe Jim Anderson. Indicate your selection by placing an X in the appropriate space next to each word.

- | | | |
|---|--|--|
| <input type="checkbox"/> active | <input type="checkbox"/> healthy | <input type="checkbox"/> rude |
| <input type="checkbox"/> affectionate | <input type="checkbox"/> helpful | <input type="checkbox"/> self-centered |
| <input type="checkbox"/> alert | <input type="checkbox"/> hostile | <input type="checkbox"/> self-confident |
| <input type="checkbox"/> appreciative | <input type="checkbox"/> humorous | <input type="checkbox"/> self-controlled |
| <input type="checkbox"/> awkward | <input type="checkbox"/> imaginative | <input type="checkbox"/> self-pitying |
| <input type="checkbox"/> bitter | <input type="checkbox"/> impatient | <input type="checkbox"/> selfish |
| <input type="checkbox"/> calm | <input type="checkbox"/> industrious | <input type="checkbox"/> shallow |
| <input type="checkbox"/> careless | <input type="checkbox"/> initiative | <input type="checkbox"/> shiftless |
| <input type="checkbox"/> cheerful | <input type="checkbox"/> intolerant | <input type="checkbox"/> show-off |
| <input type="checkbox"/> clear-thinking | <input type="checkbox"/> inventive | <input type="checkbox"/> sincere |
| <input type="checkbox"/> complaining | <input type="checkbox"/> irresponsible | <input type="checkbox"/> slipshod |
| <input type="checkbox"/> conceited | <input type="checkbox"/> irritable | <input type="checkbox"/> snobbish |
| <input type="checkbox"/> confident | <input type="checkbox"/> jolly | <input type="checkbox"/> spineless |
| <input type="checkbox"/> confused | <input type="checkbox"/> kind | <input type="checkbox"/> stable |
| <input type="checkbox"/> conscientious | <input type="checkbox"/> mannerly | <input type="checkbox"/> steady |
| <input type="checkbox"/> cooperative | <input type="checkbox"/> masculine | <input type="checkbox"/> stingy |
| <input type="checkbox"/> cowardly | <input type="checkbox"/> nagging | <input type="checkbox"/> strong |
| <input type="checkbox"/> cruel | <input type="checkbox"/> natural | <input type="checkbox"/> sulky |
| <input type="checkbox"/> deceitful | <input type="checkbox"/> obnoxious | <input type="checkbox"/> sympathetic |
| <input type="checkbox"/> dependable | <input type="checkbox"/> organized | <input type="checkbox"/> tactful |
| <input type="checkbox"/> despondent | <input type="checkbox"/> original | <input type="checkbox"/> tactless |
| <input type="checkbox"/> determined | <input type="checkbox"/> patient | <input type="checkbox"/> thankless |
| <input type="checkbox"/> energetic | <input type="checkbox"/> pleasant | <input type="checkbox"/> tolerant |
| <input type="checkbox"/> fairminded | <input type="checkbox"/> posed | <input type="checkbox"/> touchy |
| <input type="checkbox"/> fickle | <input type="checkbox"/> prejudiced | <input type="checkbox"/> trusting |
| <input type="checkbox"/> foolish | <input type="checkbox"/> progressive | <input type="checkbox"/> undependable |
| <input type="checkbox"/> foresighted | <input type="checkbox"/> quarrelsome | <input type="checkbox"/> understanding |
| <input type="checkbox"/> forgetful | <input type="checkbox"/> queer | <input type="checkbox"/> unfriendly |
| <input type="checkbox"/> gloomy | <input type="checkbox"/> quitting | <input type="checkbox"/> unintelligent |
| <input type="checkbox"/> good-natured | <input type="checkbox"/> rational | <input type="checkbox"/> unkind |
| <input type="checkbox"/> greedy | <input type="checkbox"/> rattlebrained | <input type="checkbox"/> warm |
| <input type="checkbox"/> handsome | <input type="checkbox"/> relaxed | <input type="checkbox"/> weak |
| <input type="checkbox"/> hasty | <input type="checkbox"/> resentful | <input type="checkbox"/> winny |
| | <input type="checkbox"/> resourceful | |

DIRECTIONS: The following inventory contains a list of statements that refer to Jim Anderson. Read each item carefully and determine if it is true for you. Place an "X" at the appropriate place on the line below each item to indicate that you either agree with the statement, disagree with the statement, or are uncertain as to whether you agree or disagree. Take care to mark your X's directly over the appropriate word, not on the boundaries between words.

1. If I owned and managed a small store and needed to hire another employee and this man applied for the job, I would be inclined to hire him.

/ _____ /
Disagree Uncertain Agree

2. If I were working for this man, I would probably think he was a good boss.

/ _____ /
Disagree Uncertain Agree

3. I would be willing to work with someone like this as a partner on a school project.

/ _____ /
Disagree Uncertain Agree

4. If this man lived next door to me and I needed a babysitter for an evening, I think I might ask him to babysit.

/ _____ /
Disagree Uncertain Agree

5. If I had a room to rent in my home, I would be willing to rent it to someone like this.

/ _____ /
Disagree Uncertain Agree

6. I would be willing to have someone like this join a favorite club or organization of mine.

/ _____ /
Disagree Uncertain Agree

7. If this man were running for a local public office, I would not vote for him.

/ _____ /
Disagree Uncertain Agree

APPENDIX D: SEMANTIC DIFFERENTIAL

DIRECTIONS: On the scales below, please rate Jim Anderson in relation to the adjectives listed. Here is an example of how you are to use these scales.

Example:

Neat 1 : 2 : 3 : 4 : 5 : 6 : 7 Sloppy

1. If you feel that Jim Anderson is EXTREMELY neat, you would mark an X in the first space.
2. If you feel that he is QUITE neat (but not extremely), mark an X in the second space.
3. If you feel he is only SLIGHTLY neat, mark space 3.
4. If you feel he is neither neat nor sloppy (NEUTRAL), mark space 4.
5. If you feel he is only SLIGHTLY sloppy, mark space 5.
6. If you feel he is quite sloppy (but not extremely), mark space 6.
7. If you feel he is EXTREMELY sloppy, mark space 7.

IMPORTANT:

1. Place your check marks in the middle of space, not on the boundaries.
2. Be sure to check every scale, even if it seems unusual to you.
3. Never put more than one check mark on a single scale.
4. Don't spend more than a few seconds marking each scale. It is the first idea that comes to mind that we want. However, please do not be careless, because we want your true impressions.

1. Wise _____ : _____ : _____ : _____ : _____ : _____ : _____ Foolish
2. Familiar _____ : _____ : _____ : _____ : _____ : _____ : _____ Strange
3. Intelligent _____ : _____ : _____ : _____ : _____ : _____ : _____ Ignorant
4. Active _____ : _____ : _____ : _____ : _____ : _____ : _____ Passive
5. Sincere _____ : _____ : _____ : _____ : _____ : _____ : _____ Insincere
6. Predictable _____ : _____ : _____ : _____ : _____ : _____ : _____ Unpredictable
7. Strong _____ : _____ : _____ : _____ : _____ : _____ : _____ Weak

DIRECTIONS: Please answer the following questions. For questions one and three, place an X over one of the two lines on the left. For questions two and four, place an X in the scale over the line which best represents how you feel.

- Very** _____ **Extremely**
Unsure : : : : : : **Confident**

Please answer the following questions.

1. Sometimes psychologists disguise the true meaning of experiments in order to get valid data. Do you think the true nature of this experiment was disguised? Please circle: Yes No
2. If you answered "Yes" to question 1, write what you think the true purpose of this experiment was.

DANGEROUSNESS RATING SCALES

Paranoid Schizophrenia (Labeled)

How dangerous are paranoid schizophrenics?

Very Safe _____:_____:_____:_____:_____:_____ Very Dangerous

Paranoid Schizophrenia (Symptom Description)

How dangerous are individuals who are highly paranoid and falsely believe others are plotting to harm them?

Very Safe _____:_____:_____:_____:_____:_____ Very Dangerous

Alcoholism (Labeled)

How dangerous do you think alcoholics are?

Very Safe _____:_____:_____:_____:_____:_____ Very Dangerous

Alcoholism (Symptom Description)

How dangerous is a person who drinks heavily and is unable to quit even though the drinking results in social and physical problems?

Very Safe _____:_____:_____:_____:_____:_____ Very Dangerous

Major Depression (Labeled)

How dangerous is a person suffering from a major depressive episode?

Very
Safe _____:_____:_____:_____:_____:_____ Very
Dangerous

Major Depression (Symptom Description)

How dangerous are individuals who are extremely sad and think of killing themselves to end their suffering?

Very
Safe _____:_____:_____:_____:_____:_____ Very
Dangerous

Mental Illness (Labeled)

How dangerous is a person with a mental illness?

Very
Safe _____:_____:_____:_____:_____:_____ Very
Dangerous

Mental Illness (Symptom Description)

How dangerous is a person who is moody and irritable and frequently experiences strong feelings of anxiety and fears of rejection?

Very
Safe _____:_____:_____:_____:_____:_____ Very
Dangerous

APPLICANT HISTORY: PARANOID SCHIZOPHRENIC DESCRIPTION AND LABEL

Jim Anderson was born and raised in a large Midwestern city along with one older brother and a younger sister. His mother was a nurse in a local hospital, and his father was employed as a high school teacher. Jim reports that his early years were generally pretty happy. He was active in several sports, both in school and with groups of neighborhood boys. Jim obtained average grades in high school and was particularly interested in business and literature courses.

Jim secured a job as a clerk in a hardware store after graduating from high school and worked in that position for two years. However, as that job gave him little opportunity for advancement, he eventually quit and accepted a higher paying position selling furniture in a large department store. Approximately one year after beginning his job as a salesman, Jim began to experience personal difficulties. He became increasingly suspicious of his friends, co-workers, and family and began to think everyone was against him. At times he thought people on the street were talking about him or following him. Jim became increasingly fearful and withdrawn and began to believe everyone was part of a plot to harm him. He stopped using his home phone as he feared the CIA had tapped the line to gather evidence against him. Jim eventually quit his job, and with the encouragement of his family, he entered a local psychiatric hospital to seek treatment for his problems. (A psychiatrist in the hospital diagnosed Jim's condition as paranoid schizophrenia.)*

After being released from the hospital, Jim eventually obtained another job as a salesman in a large retail store. He has worked there for several years and has recently been given the responsibility of supervising and training new employees. During the past few years, Jim also dated and eventually married a woman he had met through one of his friends. He and his wife now have a one-year-old boy.

Jim has been taking business classes at a local community college in the evenings and hopes to eventually earn a degree in business management. He is currently applying for other jobs in the business field. He is dissatisfied with his present job because it offers no opportunity for further advancement and does not pay a high enough salary.

*Note: The sentence enclosed in parentheses contains the diagnostic label and will, therefore, be used in the labeling condition and omitted in the behavioral description condition.

APPLICANT HISTORY: ALCOHOLIC DESCRIPTION AND LABEL

Jim Anderson was born and raised in a large Midwestern city along with one older brother and a younger sister. His mother was a nurse in a local hospital, and his father was employed as a high school teacher. Jim reports that his early years were generally pretty happy. He was active in several sports, both in school and with groups of neighborhood boys. Jim obtained average grades in high school and was particularly interested in business and literature courses.

Jim secured a job as a clerk in a hardware store after graduating from high school and worked in that position for two years. However, as that job gave him little opportunity for advancement, he eventually quit and accepted a higher paying position selling furniture in a large department store. Approximately one year after beginning his job as a salesman, Jim began to drink quite heavily. He realized that the alcohol was making him irritable and inefficient at home and at work, but he was unable to stop drinking despite several serious attempts. Eventually, he found himself drinking daily, and he noticed that he became anxious and fidgety if he was without a drink for a very long period of time. He also discovered that he now needed to drink large quantities to get the same relaxed feeling he once got from a couple of beers. With the encouragement of his family, Jim eventually quit his job and entered a local psychiatric hospital to obtain treatment for his drinking problem. (A psychiatrist at that hospital diagnosed Jim's condition as alcoholism.)*

After being released from the hospital, Jim eventually obtained another job as a salesman in a large retail store. He has worked there for several years and has recently been given the responsibility of supervising and training new employees. During the past few years, Jim also dated and eventually married a woman he had met through one of his friends. He and his wife now have a one-year-old boy.

Jim has been taking business classes at a local community college in the evenings and hopes to eventually earn a degree in business management. He is currently applying for other jobs in the business field. He is dissatisfied with his present job because it offers no opportunity for advancement and does not pay a high enough salary.

*Note: The sentence enclosed in parentheses contains the diagnostic label and will, therefore, be used in the labeling condition and omitted in the behavioral description condition.

APPLICANT HISTORY: DEPRESSIVE DESCRIPTION AND LABEL

Jim Anderson was born and raised in a large Midwestern city along with one older brother and a younger sister. His mother was a nurse in a local hospital, and his father was employed as a high school teacher. Jim reports that his early years were generally happy. He was active in several sports, both in school and with groups of neighborhood boys. Jim obtained average grades in high school and was particularly interested in business and literature courses.

Jim secured a job as a clerk in a hardware store after graduating from high school and worked in that position for two years. However, as that job gave him little opportunity for advancement, he eventually quit and accepted a higher paying position selling furniture in a large department store. Approximately one year after he began his job as a salesman, Jim began to feel increasingly despondent. He became highly self-critical and lost interest in a number of social and recreational activities he had previously enjoyed. He seemed to lack the energy to perform even simple tasks and had a difficult time making even minor decisions. Jim became more and more apathetic and withdrawn. As his feelings of worthlessness and hopelessness grew, he began to entertain thoughts of killing himself. With the encouragement of his family, Jim eventually quit his job and entered a local psychiatric hospital to obtain treatment for his problems. (A psychiatrist at that hospital diagnosed Jim's condition as a major depressive episode.)*

After being released from the hospital, Jim eventually obtained another job as a salesman in a large retail store. He has worked there for several years and has recently been given the responsibility of supervising and training new employees. During the past few years, Jim also dated and eventually married a woman he had met through one of his friends. He and his wife now have a one-year-old boy.

Jim has been taking business classes at a local community college in the evenings and hopes to eventually earn a degree in business management. He is currently applying for other jobs in the business field. He is dissatisfied with his present job because it offers no opportunity for further advancement and does not pay a high enough salary.

*Note: The sentence enclosed in parentheses contains the diagnostic label and will, therefore, be used in the labeling condition and omitted in the behavioral description condition.

APPLICANT HISTORY: "MENTAL ILLNESS" DESCRIPTION AND LABEL

Jim Anderson was born and raised in a large Midwestern city along with one older brother and a younger sister. His mother was a nurse in a local hospital, and his father was employed as a high school teacher. Jim reports that his early years were generally happy. He was active in several sports, both in school and with groups of neighborhood boys. Jim obtained average grades in high school and was particularly interested in business and literature courses.

Jim secured a job as a clerk in a hardware store after graduating from high school and worked in that position for two years. However, as that job gave him little opportunity for advancement, he eventually quit and accepted a higher paying position selling furniture in a large department store. Approximately one year after beginning his job as a salesman, Jim began to experience personal difficulties. He became very touchy and lost his temper quickly when things weren't going his way and when others found fault with him. He also worried more and more about little things and was moody much of the time. He had a hard time following through with plans and often put off making decisions fearing that he would make a serious mistake. At times he felt an overwhelming need to be with other people; at other times he felt an equally compelling desire to just be alone. He also spent much of the time worrying about things that might go wrong. Jim didn't understand what was causing these strong changes in his emotions. Eventually, however, he quit his job, and with the encouragement of his family, he entered a local psychiatric hospital to seek treatment for his problems. (A psychiatrist in the hospital diagnosed Jim's condition as a mental illness.)*

After being released from the hospital, Jim eventually obtained another job as a salesman in a large retail store. He has worked there for several years and has recently been given the responsibility of supervising and training new employees. During the past few years, Jim also dated and eventually married a woman he had met through one of his friends. He and his wife now have a one-year-old boy.

Jim has been taking business classes at a local community college in the evenings and hopes to eventually earn a degree in business management. He is currently applying for other jobs in the business field. He is dissatisfied with his present job because it offers no opportunity for further advancement and does not pay a high enough salary.

*Note: The sentence enclosed in parentheses contains the diagnostic label and will, therefore, be used in the labeling condition and omitted in the behavioral description condition.

APPLICANT HISTORY: CONTROL CONDITIONS

Jim Anderson was born and raised in a large Midwestern city along with one older brother and a younger sister. His mother was a nurse in a local hospital, and his father was employed as a high school teacher. Jim reports that his early years were generally happy. He was active in several sports, both in school and with groups of neighborhood boys. Jim obtained average grades in high school and was particularly interested in business and literature courses.

Jim secured a job as a clerk in a hardware store after graduating from high school and worked in that position for two years. However, as that job gave him little opportunity for advancement, he eventually quit and accepted a higher paying position selling furniture in a large department store. After working in that position for slightly more than a year, Jim moved into another sales position in a large retail store. He has worked there for several years and has recently been given the responsibility of supervising and training new employees. (His supervisor describes Jim as an efficient worker who responds well to stress.)*

During the past few years, Jim also dated and eventually married a woman he met through one of his friends. He and his wife now have a one-year-old boy and have recently purchased a new home. Jim has also been taking business classes at a local community college in the evenings and hopes to eventually earn a degree in business management. He is currently applying for other jobs in the business field. He is dissatisfied with his present job because it offers no opportunity for further advancement and does not pay a high enough salary.

*Note: The sentence enclosed in parentheses will be used in one control group and omitted in the other.

TRANSCRIPT FOR SIMULATED JOB INTERVIEW

Interviewer (I): Well Mr. Anderson, I've had a chance to look over your application, and it looks pretty sound.

Applicant (A): Thank you, Mr. Nelson.

I: I wonder if we could first talk a bit about your current job. Tell me something about McGees Department Store.

A: O.K. McGees is a large retail outfit that sells a wide variety of clothing goods, furniture, and household goods and appliances. We are one of ten McGees stores located throughout the midwest.

I: What do you do at McGees?

A: Well, I do a variety of things right now. When I started off, I spent all of my time as a salesman in the furniture department. I also worked in housewares and hardware from time to time when other employees were on vacation. I still spend part of my time selling furniture, and that time varies from week to week. But I am also responsible for filling out purchasing requests, and I help supervise and train new employees.

I: I see. Can you tell me what aspects of your job you like most.

A: Well, let me think for a second. I guess I like most everything in the job. When sales are up, it can be very stimulating. I especially like the managerial aspects of my job such as determining what to purchase for our department and when the best time to buy would be. I guess I like the challenge of keeping it all organized. I also like training new help.

I: O.K. Now perhaps we might turn the coin over. What are some things about your job you dislike?

A: One of the things I don't like too much anymore is the sales aspect of my job. It can be O.K. when the economy is good and lots of people are buying, but lately things have been really slow and I've been very bored. I just don't think I want to do sales work anymore; I'm more interested in managerial positions. I really like the supervisory work I do now. Unfortunately, McGees doesn't have much of a turnover in their managerial staff, so if I stay there, I will probably be stuck in my present position for a long time.

I: I see. Well now, your application indicates that you worked in the housewares department at Marks and Robinson before you began at McGees. Is that correct?

A: Yes. I worked there for approximately a year selling furniture and household appliances.

I: What did you think about that job?

A: Well, to be honest, it wasn't a very good company to work for.

I: Can you elaborate on that?

A: Yes. I guess I just don't think it was well managed. They had outdated and confusing purchasing and billing procedures. Half the time, customers would complain because we were out of particular items or because they had to wait too long to get shipments we promised them. Management also made lots of promises to staff regarding salary increases and bonuses that were seldom kept. They also put lots of pressure on us to increase our sales volume.

I: It sounds like you were dissatisfied about a lot of things that were happening there. Did you talk to your supervisor about any of your concerns?

A: I tried. I talked to my supervisor, Mr. Johnson, but that turned out to be a waste of time. I don't mean to sound unkind, but he was a very difficult person to work for. He was very nervous, and I can understand that because he had a lot of responsibilities, but he just wasn't open to feedback from his staff. I think he felt threatened and wanted to make sure we knew who was boss. I don't think anyone was ever able to please Mr. Johnson. He kind of expected miracles, and I don't think anyone could have performed to his satisfaction.

I: It seems like you are more satisfied with your current job with McGees than you were at Marks and Robinson.

A: That's certainly true. McGees is a much more efficient place to work at. They also pay much better and treat their staff better.

I: What do you think of your supervisor on this job?

A: I like him pretty well. We don't always see eye to eye on everything, but he usually seems to value my opinion.

I: Can you give me a recent example when you didn't agree with him, and tell me how you worked it out.

A: . . . well . . . yes. About two months ago we hired a man, and I was given the responsibility of breaking this man in. It quickly became apparent to me that he wasn't going to be cut out for the job. He consistently came to work late, even after I stressed repeatedly how important it was for him to be on time, and he had a really hard time talking to customers. I suggested to Mike Evans, my boss, that we either transfer the employee to another department where he would have less contact with people or let him go. Mike didn't think I'd given him enough of a chance. I thought I'd given the employee plenty of time to improve and told Mike so, but I agreed to try working with him one more month. The employees' performance deteriorated even further, as I predicted, and we eventually had to fire him.

I: O.K. Mr. Anderson, how would you say your current job has prepared you for greater responsibilities?

A: Hum . . . I think mostly by exposing me to a variety of aspects of the retail business. As I've already stated, it's given me exposure to several different departments and to various tasks including sales, purchasing, and some

- A: (continued) supervision of employees. I think my having started at the bottom of a retail organization will help me be a more effective administrator as I move on up into management. Hopefully, I'll have a understanding for the day to day hassels of being a salesman that I would not have if I had come right into a managerial position from college without having had any direct retail experience.
- I: Speaking of college, why don't we shift gears a bit now and talk about your educational background. You're currently taking classes at the University, is that correct?
- A: Yes, I've been taking night classes for several years. I'm working toward a degree in business management.
- I: I see. How much longer will it take for you to get your degree?
- A: Well, I only have enough time to take about two classes a quarter while I'm working full time. At that rate, it will probably take about another year for me to finish.
- I: What sorts of business courses have you completed?
- A: I had classes in business law, business writing, marketing, and personnel management and I've taken several accounting courses.
- I: I'm curious, why did you decide to wait a few years to go to college rather than go immediately after high school.
- A: Well, when I first graduated from high school I really didn't know what I wanted to do. Finances were also pretty tight. I didn't have but a few dollars from previous summer jobs in my savings account, and my parents didn't have any extra money for my tuition. So, I decided to work for awhile, save some money, and decide what sort of a career I wanted.
- I: How did you finally decide to major in business management, then?
- A: That's a little hard to answer as no one thing or event helped me make that decision. I think my jobs at both Marks and McGees have increased my interest in the retail business. I've really enjoyed the managerial and supervisory aspects of my current job, and wanted a degree that would allow me to do more of that kind of thing in the future.
- I: How are your grades in school?
- A: So far, I have about a 3.0 grade average.
- I: Are there courses that have been particularly difficult for you?
- A: Well . . . if I had to pick one or two, I think I'd say business statistics and advanced accounting courses were a bit tough. I'm a really good writer, but working with numbers is more difficult for me.
- I: Have you had, or will you have much exposure to computer usage. We are currently using computers more and more in our organization and certainly

- I: (continued) need individuals with knowledge in that area.
- A: I think I might be of help there. I've had two courses in computer programming and plan to take one more before I get my degree.
- I: That's good to hear. (pause) Mr. Anderson, if you had to describe yourself to someone who didn't know you, what would you say.
- A: I guess, um . . . I guess I'd say I was a sort of friendly, easy-going type of guy who gets along o.k. with most people.
- I: What would you consider to be your more outstanding strengths and qualities?
- A: Well, I'm not one to blow my own horn, but I guess when you're going for a job one has to, at least to some extent?
- I: That's probably true, Mr. Anderson (pause).
- A: Let's see. Well, I guess I'm pretty loyal, hardworking, and conscientious, and I'm good at organizing things.
- I: Would you say you had good administrative skills?
- A: Yes, I think so Mr. Nelson. I think I'm pretty good at solving problems when they come up and I try hard to keep things organized and running smoothly and efficiently.
- I: My next question might be a little harder to answer, Mr. Anderson. You have told me about your strong points, now tell me about some of your limitations and areas you would like to improve?
- A: (pause) You're right. That's a lot harder to answer. (pause) Well (somewhat hesitantly), I suppose in the past I may not always have been as assertive as I might have been, you know, pushed for what I felt was right and needed.
- I: You haven't always been as strong or forceful as you would have liked to be.
- A: Perhaps so. I mean, I'm not a demanding, desk-pounding type of person. I think early on in my job history, I was a bit too reserved in advancing my own career or expressing my dissatisfaction when I didn't think a fellow employee was holding up his fair share of the work load. But I think over time I've become more assertive and aggressive in getting things done and getting my viewpoint across.
- I: O.K. What would you say are some of the personal qualities you like to have in people who work for you?
- A: Well, first I guess I like to have people who are honest and reliable and people who don't have to be constantly told what to do. I also like employees, who are easy to talk to and don't complain a lot, and those who don't get bent out of shape when I tell them they aren't doing something the way it is supposed to be done.
- I: What about your supervisors? What sorts of qualities do you like and dislike in people who supervise you.

- A: I guess I like supervisors who respect my opinions and ideas and will listen to my concerns. I'm not crazy about the authoritarian, demanding type who don't listen to their staff and think their way of doing things is the only way. I guess I like having some freedom to be creative and try out things I think will work best.
- I: I see, Mr. Anderson. Tell me, what are you looking for in a new job.
- A: I'm looking for a job with a larger company than my present one. I want a job that offers a somewhat better chance for advancement than I have now. As I indicated before, I want to move further into management. I'd really like to have a chance to run my own department. I want to have more responsibility than I have and the freedom to make more decisions without having to clear them through someone else.
- I: What about your long-term career objectives? What do you see yourself doing five or ten years from now?
- A: What I hope to do is to first move into a position as department manager in a large company like yours. I want to learn all I can while I'm in that position and see how effective a job I do. In time, then, I hope to gradually move up in the organization, although I'm not sure precisely what position I would hope for, perhaps a district manager position where I would oversee and evaluate the operations of several stores. I'm not sure at this point.
- I: One of the things that is important to us, Mr. Anderson, is that we hire help who plan to be with us for some time. Do you plan to stay in this area after you finish your course work at the University.
- A: That would of course depend on whether or not I obtain satisfactory employment here. If I do, I would definitely stay. My wife and I are very happy here. We have good neighbors and friends and we both have parents and other relatives who live reasonably close. And in addition, this area has really good schools, which will be an important consideration in a few years when, Brian, our one-year-old, is ready to go to school.
- I: So it sounds like you would prefer to stay in this area if you could?
- A: That's definitely true.
- I: Good. Mr. Anderson, I'm also interested to know what kinds of things you do with your time when you're not at work? What do you do for fun and recreation?
- A: Well, I'm afraid I don't have much time left over for leisure after I go to work, take classes, and help Nancy, my wife, take care of Brian and other household responsibilities. When we do have time, we go to movies and football games or just have friends over for dinner. Nancy talks me into going bowling once in a while too, but I don't enjoy that as much as she does.
- I: Do you presently belong to any social or professional clubs or organizations?
- A: No, I don't. I just don't have the time for that kind of thing right now.

I: It does sound like you have a pretty busy schedule. (pause) Perhaps now would be a good time for me to give you some information about our company and the job we have open.

A: Yes, I would like that.